DOCUMENT RESUME

ED 464 292 CG 031 714

AUTHOR	Cermele, Debra E., Ed.
TITLE	Directions in Marriage and Family Therapy, 1994.
INSTITUTION	Hatherleigh Co., Ltd., New York, NY.
PUB DATE	1994-00-00
NOTE	106p.; Continuing education credit may be available based on completion of questions following each lesson (contact publisher for requirements).
AVAILABLE FROM	The Hatherleigh Company, Ltd., 5-22 46th Ave., Suite 200, Long Island City, NY 11101 ($75). Tel: 800-367-2550 (Toll Free); Tel: 212-832-1039.
PUB TYPE	Collected Works - Serials (022) -- Guides - Classroom - Learner (051)
JOURNAL CIT	Directions in Marriage and Family Therapy; v2 n1-6 1994
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	Abortions; *Counseling Techniques; Death; Family Caregivers; *Family Counseling; Feminism; *Marriage Counseling; Posttraumatic Stress Disorder; Sexuality
IDENTIFIERS	Individualized Service Plans

ABSTRACT

In an effort to help practitioners deal with the great volume of current literature in the field of marriage and family therapy, this compilation attempts to present clinically relevant material in a user-friendly format. Topics selected for inclusion are believed to be up-to-date, informative, and clinically meaningful--as well as theoretically based and empirically grounded. The lessons, which may be applied toward continuing education credits, are: (1) "A Problem-Centered Approach to Interviewing in Family Therapy" (Donald R. Catherall); (2) "Identification, Assessment, and Treatment of Women Suffering from Post-Traumatic Stress after Abortion" (Dennis A. Bagarozzi); (3) "The Death of a Child: Implications for Marital and Family Therapy" (Paula P. Bernstein and Leslie A. Gavin); (4) "Feminist and Traditional Family Therapies" (Barbara L. Brown and Margot W. Hartner); (5) "Family Caregiving of the Elderly" (Juanita L. Garcia and Jordan I. Kosberg); (6) "Relational Sexuality: An Understanding of Low Sexual Desire" (Lynda Dykes Talmadge and William C. Talmadge); and a special report on The Individualized Family Service Plan (Harvey Koanning, Alan Demmitt, Dorris Whiddon, Susan McBride, and Mary Jane Brotherson). Contains references at the end of each lesson. (GCP)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 464 292

Directions in Marriage and Family Therapy

Volume 2

1994

Debra E. Cermele, Editor

CG031714

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

K. Moran

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

BEST COPY AVAILABLE

Directions in Marriage and Family Therapy

TABLE OF CONTENTS

Introduction
Dennis A. Bagarozzi, PhD

Lesson 1
A Problem-Centered Approach to Interviewing in Family Therapy
Donald R. Catherall, PhD

Lesson 2
Identification, Assessment, and Treatment of Women Suffering from Post-Traumatic Stress After Abortion
Dennis A. Bagarozzi, PhD

Lesson 3
The Death of a Child: Implications for Marital and Family Therapy
Paula P. Bernstein, PhD, and Leslie A. Gavin, PhD

Lesson 4
Feminist and Traditional Family Therapies
Barbara L. Brown, PhD, and Margot W. Harter, PhD

Lesson 5
Family Caregiving of the Elderly
Juanita L. Garcia, EdD, and Jordan I. Kosberg, PhD

Lesson 6
Relational Sexuality: An Understanding of Low Sexual Desire
Lynda Dykes Talmadge, PhD, and William C. Talmadge, PhD

Special Report
The Individualized Family Service Plan
Harvey Joanning, PhD, Alan Demmitt, MA, Dorris Whiddon, MS, Susan McBride, PhD, and Mary Jane Brotherson, PhD

VOLUME 2

1994

DIRECTIONS IN MARRIAGE AND FAMILY THERAPY

Special Program Coordinators
Dennis A. Bagarozzi, PhD
Frederic Flach, MD

Editorial Board of Consultants
James Alexander, PhD
Stephen Anderson, PhD
Judith I. Bagarozzi, MS
Insoo Kim Berg, MSSW
William J. Doherty, PhD
Craig Everett, PhD
Charles Figley, PhD
Alan S. Gurman, PhD
Harvey Joanning, PhD
Florence Kaslow, PhD
James F. Keller, PhD
Luciano L'Abate, PhD
Pieter le Roux, PhD
Howard Liddle, PhD
Mel Markowski, PhD
Fred P. Piercy, PhD
Lynda Dykes Talmadge, PhD

Managing Editor
Debra E. Cermele

Associate Editor
Steven L. Pessagno

Directions in Marriage & Family Therapy is a continuing education program published by The Hatherleigh Company, Ltd., 420 East 51 Street, New York NY 10022.
For additional information, please call 800-367-2550 or 212-355-0882 (outside the US).

© 1994, The Hatherleigh Company, Ltd
All rights reserved. Not to be reprinted without permission of the publisher.

Directions in Marriage and Family Therapy

VOLUME 2

Introduction

Dennis A. Bagarozzi, PhD

Dr. Bagarozzi is President of Georgia Preferred Inc,
and is in private practice in Atlanta, GA, and Athens, GA.

INTRODUCTION

In 1966, when I began work on my MSW degree at Hunter College, there were only a few students interested in learning family therapy. The only professional journal devoted to family intervention, *Family Process*, was in its infancy, and there were less than a dozen books published on the subject. Those of us who did attempt to practice family therapy in our field placements did so with little or no formal supervision. We flew by the seats of our pants and traded clinical "war stories" over cups of coffee in the student cafeteria. How nice it would have been to have had access to some concrete guidelines for conducting family interviews such as those presented by Dr. Catherall in the first lesson of this volume. As Dr. Catherall points out, we learned quickly that nondirective interviewing styles were inappropriate for work with families. Our approaches to family therapy, which evolved over our 2 years of graduate education, came from another area—our work in group process and group dynamics. All of us whose Master's theses dealt with family therapy (not surprisingly) had majored in "social group work."

When I began my formal post-masters training, I quickly realized how little I actually knew about doing family therapy. My training experience (under the direction of Andy Ferber, MD, who was then the Director of the Family Studies Section of the Bronx State Hospital/ Albert Einstein College of Medicine in New York) was always exciting, sometimes frightening, but never dull or boring. However, the training program itself was loosely structured. We were urged to discover our own personal styles as well as our own approaches to family intervention. I am sure that some of my anxiety about the uncertainty of what I was doing would have been reduced somewhat if I had been introduced to a systematic intervention structure like the one described by Dr. Catherall. I think that all of you who are newcomers to family work will have your anxieties decreased by studying this lesson, but I hope your excitement about doing family therapy stays with you forever.

It has become accepted family therapy lore that when a child is presented as the "identified patient," his or her symptomatic behavior symbolically represents some unresolved marital and/or family conflict that the parents cannot address openly and directly. Drs. Bernstein and Gavin make this assumption and then skillfully demonstrate how the pain evidenced by the identified patients in their case examples actually represent an even broader family pain that the parents are unable to confront—the pain of loss associated with the death and unresolved mourning of a beloved child. Impacted grief is not uncommon in cases of post-traumatic stress where denial is used to avoid the hurt of loss. Helping family members acknowledge their suffering without precipitating a premature termination of therapy takes a considerable amount of clinical skill and expertise on the part of the therapist. Drs. Bernstein and Gavin offer some extremely helpful clinical guidelines for dealing with this sensitive issue.

These authors also underscore what I have experienced in my clinical work with many families who use denial as their primary group defense: It is usually the men who are more likely to want to put the tragedy behind them in an effort to protect other family members and themselves from experiencing, processing, and working through disturbing feelings.

The differences between how men and women express their true feelings is something to which family therapists should be attuned. For example, many men have been socialized not to express feelings of hurt, loss, or sadness. They are more likely to respond with anger or, sometimes, aggression. We, as a society, seem more willing to excuse angry and aggressive responses by men when they are obviously hurt. Conversely, women are socialized *not* to experience or express their anger, and aggression in women is, for the most part, unacceptable. Indeed, women are socialized to hide their anger behind tears of rage. Both sexes are trapped by their own socialization and sex–role expectations for male and female behavior. Unfortunately, this socialization process serves as a major barrier to true intimacy between men and women.

Not all sexism is as blatant as one finds in cases of domestic violence and spouse abuse. Lesson 3, by Drs. Brown and Harter, makes us uncomfortably aware of the insidious nature of sexism and the subtle way such biases have been perpetuated by unwitting family therapists and theories of family therapy. I believe that this lesson on feminist and traditional family therapies will prove to be an eye opener for many readers—both male and female.

Although there are a number of differences between feminist and traditional approaches to family therapy, one of these differences discussed by Drs. Brown and Harter

INTRODUCTION

struck me as particularly important—the feminist view of how systems function. They question the basic theoretical and epistemologic tenet of circular causality and postulate that a linear model of family process may apply in some instances, such as spouse abuse. Viewing the presenting problem from this perspective forces us to question the wisdom of using family-focused treatments in some instances. Although I have heard it said by some family therapists that "in the end, all therapy (individual, group, or otherwise) is actually family therapy," Drs. Brown and Harter offer us a much-needed alternative perspective from which to view and treat what many family therapists traditionally consider to be a "family problem."

Drs. Garcia and Kosberg's lesson deals with a complex set of problems and issues that one rarely sees addressed in the "mainstream" family therapy literature. The logistics of working with families who are involved with giving care to elderly parents and extended family members does not seem to catch the interest of many family therapists. Debates about epistemology, discussions of sexism and racism in the practice of marital and family therapy, and concerns about family therapy in an age of managed care (just to name a few) make much more interesting reading than do the statistics, demographics, mundane concerns, and concrete suggestions for working with the elderly that Drs. Garcia and Kosberg offer in their lesson. *But this is really what family therapy is all about—intergenerational reciprocity, respect and responsibility for those who took responsibility for us when we were unable to care for ourselves.* Although not explicitly stated, the authors' focus on family caregiving actually deals with the very soul of family work—family cohesion and continuity.

The final lesson of this volume, by Drs. Talmadge and Talmadge, discusses a problem that those of us who practice sex therapy treat routinely—low sexual desire. The Talmadges point out that to treat this problem successfully, one must understand that sexual desire is not unidimensional and that it results from an interaction among a variety of factors: biologic drive, psychologic motivation, and cognitive aspiration. In addition, these authors stress the importance of looking at the emotional-relational component of this issue. They suggest that sex therapists' poor success rate for treating low sexual desire stems from their inattention to the relational aspect of this problem. Now, when one stands back and looks at this statement, it seems self-evident. How, one might question, can a therapist treat a sexual problem without taking into account the emotional relationship that exists between the two participants?

The neglect of the relational dimension in the treatment of sex therapy was a common practice until the mid-1980s. Prior to that, treatment focused on behavioral and technical issues, and many sex therapists had no formal training in marriage and/or family therapy. Again, the Talmadges note another factor that now seems obvious: "Low sexual desire is often an indicator of difficulty with marital intimacy." When one considers that there are at least eight interrelated components of marital intimacy (Bagarozzi & Anderson, 1989), it is not surprising to find that difficulties in sexual desire frequently signify that problems exist in one or more of these interrelated areas. The presenting problem of low sexual desire, especially when it is specific to one's spouse or partner, typically means that there are serious intimacy problems in the relationship.

The Talmadges offer some helpful insights and clinical strategies for dealing with this complex issue. The importance of this lesson, however, has less to do with the concrete suggestions for intervention that are presented for the reader than the understanding of low sexual desire as primarily a symbol of difficulties in the couples' relationship—especially in the area of intimacy.

Again, I would like to say that all of us at *DIMFT* hope that the lessons published in this, our second volume, are helpful to you in your work. As always, we welcome your comments, insights, and suggestions. We hope that you will continue to use *DIMFT* as a tool for professional growth and development.

— Dennis A. Bagarozzi, PhD
Atlanta, GA
July 1994

Reference

Bagarozzi, D. A., & Anderson, S. A. (1989). *Personal, marital and family myths: Theoretical formulations and clinical strategies.* New York: W. W. Norton.

Directions in Marriage and Family Therapy

VOLUME 2 • LESSON 1

A Problem-Centered Approach to Interviewing in Family Therapy

Donald R. Catherall, PhD

Dr. Catherall is Executive Director, The Phoenix Institute, Chicago, IL.

This lesson is adapted with permission from: Catherall, D. R. (1989). Interviewing in family therapy: The problem-centered approach. In J. C. Hanson (Ed.), The family therapy collections *(pp. 49–69). Rockville, MD: Aspen Publishers, Inc.*

VOL. 2, NO. 1

1994

KEY POINTS

- The problem-centered approach to interviewing families organizes multiple theoretical perspectives into a structure of clearly prioritized strategies. The primary goal is to identify and resolve the presenting problem. The family is helped to identify maladaptive problem-solving patterns and acquire more effective problem-solving mechanisms. The five levels of the intervention structure are: identifying the problem; developing solutions; implementing solutions; resolving interpersonal conflicts; and resolving intrapersonal conflicts.

- In problem-centered family therapy, the therapist should be actively involved during the early phases of treatment to identify the family's specific presenting problem, provide education about its nature, and structure its solution. He or she must establish an alliance with each individual and also with the family system as a whole.

- To identify the problem, the therapist must ascertain how each family member views the conflicts.

- When developing solutions, the therapist must help the family members reach an agreement regarding which methods are appropriate for addressing their dilemma.

- During the implementation of the solution, the therapist must help direct both insession and extrasession behavior in order to recognize whether the solution is successful and to determine why it may be failing.

- When addressing interpersonal blocks, the therapist confronts conflicts between members of the family and identifies other relationship issues that are leading to conflict.

- When resolving intrapersonal blocks, the therapist explores the intrapsychic dynamics of individual members of the patient system. The goal of intrapersonal work during family therapy is to alleviate the larger problem of interpersonal conflict. Intrapersonal work is only pursued to the extent necessary to resolve intrapersonal blocks to the *inter*personal work.

- The therapist does not necessarily follow the five steps in a strict linear fashion, but uses each when necessary in order to address family problems.

Introduction

Generations of therapists have struggled with the complexities of maintaining a therapeutic focus in the treatment of individual clients. They have been faced with a number of decisions, involving issues such as the degree to which they will structure the interview, how active and directive they will be, how they will define the therapeutic contract, and how they will build and maintain a therapeutic alliance. **The field of family therapy further complicates these decisions by introducing a new dimension to the interview: the presence of other family members.**

Family therapists quickly discovered that many techniques that work in individual therapy are contra-indicated with families. **The nondirective style of client-centered and psychoanalytic therapies is simply not possible with most families when they enter treatment.** Such families are usually in a state of crisis, are often chaotic, and need the therapist to structure the interviews so they may discuss the immediate problem in a coherent manner. **During the early phases of treatment, family therapists usually are required to be active**; passive therapists can easily lose control of interviews when families are in crisis.

Families generally enter treatment to deal with specific problems (Pinsof, 1983*a*) **rather than to increase self-understanding, personal growth, or self-actualization.** In family therapy, the therapeutic contract almost always can be defined in terms of resolving a specific problem. Virtually all forms of family therapy begin with discussing the family's presenting problem, which offers a logical focus for the interview. **Family therapy approaches begin to differ as the presenting problems are discussed and the therapist moves toward intervention strategies.** Different methods of discussing the presenting problem constitute different intervention strategies, just as deciding who must be present constitutes choosing an intervention strategy.

Family therapists view the therapeutic alliance differently from individual therapists (Pinsof & Catherall, 1986). **With a family, the therapist must establish an alliance not only with individuals but with the entire system, and must consider the effect of an alliance with any family member on the alliance with the other members.** Family members may have conflicting goals for therapy, which places the therapist in a difficult position. Family members often are divided into various coalitions and are quite sensitive to whose side the therapist takes (Sluzki, 1978). **The therapist must somehow maintain an alliance with the whole system and with the individual members, despite the conflicts and differences**.

The advent of systems theory changed not only the interpersonal context of therapy (i.e., who is present) but the overall manner in which symptoms and problems are understood. Many family therapists have been exposed to the theories and methods of individual approaches and can conceptualize the presenting problem from both intrapersonal and systemic perspectives. However, this abundance of theoretical viewpoints can lead to considerable confusion in choosing intervention strategies. Many therapists adopt one perspective and stand by it in all situations, which is not always adaptive. **A better approach is to have a theoretical framework that integrates intrapersonal and systemic perspectives. Such a framework should suggest when to employ which perspective in selecting interventions.**

The problem-centered approach (Pinsof, 1983*a*) **organizes multiple theoretical perspectives into a structure of clearly prioritized intervention strategies.** It offers a framework that structures the content of the interviews and defines the therapist's role in helping families resolve their problems. It also attends to the development and maintenance of the therapeutic alliance (Pinsof & Catherall, 1986). **The presenting problem is accepted as the central organizing feature of the therapy, and its solution is the focus of the interviews.**

The Problem-Centered Model

The problem-centered approach to family treatment was pioneered by Epstein and colleagues (1978, 1981) at McMaster University, where it became known as the McMaster model. Later, it was refined, elaborated, and extended beyond family therapy by Pinsof (1983*a*) at the Family Institute of Chicago; this researcher initially drew on Kaplan's work on sexual disorders (1974, 1979). In particular, he adopted her method of organizing theoretical models and associated interventions in a hierarchical fashion. He broadened the model into a comprehensive framework for integrating family, couple, and individual therapies. Because this lesson focuses on family therapy, readers interested in a broader examination of the conceptual framework of the model should refer to Pinsof (1983*a*) on integrative problem-centered therapy.

The goal of treatment in the problem-centered model is the resolution of the presenting problem (or any new problem the family targets), "the ultimate reference point to which all therapist interventions must be related" (Pinsof, 1983*a*). **The therapeutic task helps the family acquire more effective problem-solving mechanisms in dealing with the presenting problem and similar problems in the future. The therapist must identify maladaptive problem-solving patterns in the family and teach the family to recognize and modify them.** The therapist approaches the family system with the assumption that a constellation of factors maintain the system's inability to resolve the presenting problem and that the therapist must identify and modify this "problem maintenance structure" (Feldman & Pinsof, 1982).

The problem maintenance structure is approached in a straightforward manner. It assumes that family members are psychologically healthy, want to cooperate, and can use direct assistance. More extensive and indirect assistance is used only if the patient system proves unable to make effective use of direct minimal assistance. The problem maintenance structure is then hypothesized to be more complex and less superficial.

Intervention Structure

The interventions are ordered in a hierarchical structure that stems from the presenting problem and a consensually derived adaptive solution. Once the solution is agreed upon, the family is directed to implement the solution strategy. The therapist then assists the family and offers expertise concerning the solution strategies. **The therapist's role often is educational** and focuses on issues such as lack of information, resources, or competence in employing behavioral techniques. Interventions are directed toward improving the patient system's ability to employ the adaptive solution.

If the family cannot implement the solution with appropriate help from the therapist, the therapist must explore the problem-solving block by developing and testing hypotheses about its nature. The hypotheses are organized hierarchically and explored methodically along the block determinant continuum, which organizes hypotheses from simple explanations of a relatively immediate origin to more complex explanations of a more remote origin.

The therapist first develops and tests hypotheses that assume the block is at the level of systemic or interpersonal functioning. The therapist's role becomes less educational as he or she actively explores the interpersonal nature of the system, looking at issues such as power distribution, communication of affect, quality of structural boundaries, and assignment of roles. Interventions in this range of the block determinant continuum are directed toward surfacing suppressed emotions, resolving interpersonal conflicts, identifying and reducing catastrophic fears, and weakening inappropriately rigid boundaries or strengthening weak boundaries.

When efforts to resolve systemic block determinants fail, the therapist should explore hypotheses related to individual psychopathology. This is the most remote end of the block determinant continuum. The therapist's role here is more psychodynamic in nature, exploring the intrapsychic origins of the problem-solving block; interventions are directed toward helping the individual separate historical issues from the current situation, confront irrational fears and expectations, and build ego strength. **Successful work at this intrapersonal level is always followed, or accompanied, by further work at the interpersonal (systemic) level.** Individuals are encouraged to act on their insights to change their behavior in their ongoing intimate relationships.

The intervention structure does not correspond to the usual chronological stages of treatment, such as beginning, middle, and termination. The problem-solving blocks are pursued from immediate to remote determinants, but then the focus moves back to interpersonal and behavioral blocks. The focus can move around on the block determinant continuum, not only in resolving one blocked behavior but in pursuing new blocks and new problems. Thus, **the problem, which is the reference point of the treatment, may change as treatment progresses. The intervention structure can be expressed in terms of identifying the problem, developing solutions, implementing solutions, resolving interpersonal blocks, and resolving intrapersonal blocks. The focus of the therapy moves through these categories and may span more than one at any given point in the process.**

The Intervention Structure in Action

IDENTIFYING THE PROBLEM:

The process of identifying the problem is best accomplished with all relevant family members present. This provides the therapist with the most direct access to the significant interpersonal components of the problem maintenance structure. Hence, the initial telephone contact should be lengthy enough to establish who belongs to the system. Everyone who resides in the household should be requested to come to the initial session. Others who are strongly involved with the family should also come (e.g., extended family who live nearby). This rule applies if the problem involves a symptomatic member or a generational conflict; if the presenting problem is a marital conflict, the first session is usually conducted only with the couple.

The first goal of the initial session is to establish a beginning alliance with all family members. The second goal is to establish the nature of the presenting problem. These goals often are accomplished simultaneously as the alliance is facilitated by the manner in which the therapist investigates the problem. The alliance develops in a therapeutic atmosphere in which each member (regardless of age) is understood to have his or her own opinions and feelings.

Each member is asked to give his or her opinion on the nature of the problem, how he or she feels about the problem and the sequelae of the problem, and what he or she has done to try to solve the problem. Each aspect of this triad is explored in depth, particularly the attempted solutions. The therapist must know the specifics of how each solution was implemented and why it failed. Frequently, an appropriate solution was attempted but was not supported by all the members, not pursued long enough, or not used consistently. This process is conducted in an atmosphere of nonjudgmental data collection: the therapist is empathic with each individual's perspective but offers no opinion until all members have presented their views. **The therapist's task at this point is to clarify, empathize, and understand.**

Case Dialogue

Therapist: I would like to hear from each of you about how you see the problem. Would you like to begin, Mr. A? What do you see as the problem you are here to work on?

Mr. A: Well, the problem is our son, Jack. He's always mouthing off to his mother and won't do anything she tells him. The two of them are always arguing.

Therapist: And what have you done to try and solve this problem?

Mr. A: I tell Jack I will give him a whipping when I get home if his mother says he's mouthing off to her. And we have grounded him and taken away the use of the car.

Therapist: What about the whippings? Have you given him a whipping?

Mr. A: Several times.

Therapist: Have these things changed Jack's behavior in any way?

Mr. A: Nope, he's still arguing with her all the time.

Therapist: I see. Mrs. A, what about you, what do you see as the problem?

Mrs. A: As my husband said, Jack just won't do anything I tell him. He's disrespectful and he does as he pleases. If I try to appeal to him, all I get is smart-mouth answers.

Therapist: So how are you feeling about this problem?

Mrs. A: I'm fed up. At first, I wanted Jack to be happy with what I asked him to do. Now I don't care, I just want cooperation.

Therapist: All right, Mrs. A. Let me speak to Jack. Jack, what do you feel is the problem? Your parents both say you are disobedient and have a smart mouth. But I want to know how you see it.

Jack: I'm not disobedient. Ask them. I haven't gone out once since they grounded me. And other people don't think I'm a smart aleck. It's just my mom. She's always on my case about something. She never lets up. She's always asking questions about my friends and what I do with them. I do what she asks when it's reasonable.

Therapist: Jack, how do you feel about this constant bickering between you and your mom?

Jack: I hate it. I feel like I'm at war and there's nobody else on my side.

Therapist: Does your dad ever take your side?

Jack: No. Sometimes he just tries to stay out of it; other times he comes down on me and says I have to do whatever Mom says. But he never says she's wrong.

Therapist: What have you done to try and get along better with your mom?

Jack: I just try to be reasonable with her, but it doesn't work. She doesn't listen to me when I explain something. I know I get sarcastic sometimes, but it's because she's not listening to me.

Therapist: All right, Jack, thank you. Mrs. A, Jack says that he's not disrespectful or disobedient in general. He feels that the problem is mostly between you and him. What do you think about that?

Mrs. A: It's true that I'm the one he's always mouthing off at, but then I'm the one who has to deal with him the most.

Therapist: All right then. It sounds like we agree that the problem occurs primarily between Jack and Mrs. A, who feels Jack is disrespectful and won't cooperate with her. And Jack feels that Mom doesn't listen to him and asks unreasonable things of him. And everyone agrees that Jack and Mom are arguing too much.

DEVELOPING SOLUTIONS:

The goal of the therapy in this phase is to reach an agreement with the patient system regarding the appropriate solution to the problem. The adaptive solution considers the available resources and calls upon the family to perform behaviors that would logically help resolve the presenting problem. Previous failures to employ the same solution strategy are not considered adequate reason to ignore the strategy. **Instead, the therapist works with the family to establish agreement that the adaptive solution can resolve the presenting problem if employed effectively.**

The nature of the adaptive solution is not terribly profound nor difficult to understand. Rather, the solution is usually obvious and based on common sense; it is often something that family members have already tried. **The use of relatively sophisticated, complex, and imaginative psychological theories is not necessary in developing the adaptive solution; these theories come into play if the family cannot employ the adaptive solution.**

Usually, the therapist should begin working on identifying potential adaptive solutions by the end of the second session or the beginning of the third session.

Case Dialogue

Therapist: Now that we agree that the problem is Jack and Mrs. A arguing too much, I would like to clarify what we are working toward. Mrs. A needs Jack to speak to her more respectfully and be more cooperative. Jack needs Mrs. A to listen to him more carefully and not make unreasonable requests. If these things happen, the arguing should diminish. Let's discuss how these things can be brought about. Mrs. A, how will you know if Jack is being more respectful?

Mrs. A: He should not swear at me or say things like "That's stupid" when I ask him to do something. And he should not be sarcastic! He should stay in the room when I am talking to him and not turn his back.

Therapist: I want to make sure that you understand what it is you do that your mother feels is disrespectful.

Jack: Yeah, I understand.

Therapist: All right, let's talk about cooperation. I think the problem here is when Jack feels his mom's request is unreasonable. Mrs. A, how would you like Jack to tell you if he thinks your request is unreasonable?

Mrs. A: I certainly don't want him to say it's stupid!

Therapist: What would you prefer he say?

Mrs. A: Just that he thinks it's unreasonable.

Therapist: Can you do that, Jack?

Jack: Sure, I do it all the time but she doesn't listen.

Therapist: Do you explain why you think it's unreasonable?

Jack: Yeah.

Therapist: All right then. Mrs. A, is there a way that you can demonstrate to Jack that you listened to his explanation and understand it?

Mrs. A.: I don't know. What if I still feel my request is reasonable?

Therapist: I have an idea. How about if you use a technique called "checking it out"? Jack, if you feel your mother is not understanding your explanation, you can check it out by asking her to explain your position back to you. Then, if she doesn't understand it entirely, you can explain further. Would you be willing to do this, Mrs. A?

Mrs. A: You mean if he asks, I should tell him why he thinks my request is unreasonable?

Therapist: That's right. It's a way of demonstrating that you are listening and that you understand.

Mrs. A: Well, I can do that, but what if I still feel that my request is reasonable?

Therapist: In that case, Jack should go ahead and do whatever you are requesting. You may not like that, Jack, but your mother should still be in charge. However, I would add that in the next session we will then discuss all the requests Jack felt were unreasonable. If Jack can convince you that certain requests are unreasonable, then new rules can be negotiated. Do you understand what that means, Jack? Once your mother has demonstrated that she has listened, you must abide by her decision and save your arguments for the next session in here.

Jack: Sounds like "Jack loses" to me.

Therapist: Not necessarily. This can help stop the bickering. You do "lose" at the time of the hassle if your mother insists on your doing what she asks, but you will have an opportunity to influence the family rules so that it doesn't happen again. But until a rule changes, you must do as your mother requests. That means your mother gets the cooperation she wants and you get to make sure that she really listens to your side.

Jack: Yeah, okay. I'll try it.

IMPLEMENTING SOLUTIONS:

When an adaptive solution has been established, the focus of the therapy shifts to its implementation. The therapist's role changes: He or she is no longer simply clarifying, understanding, and exploring options, but **coaching in session behavior and directing extrasession behavior.** The therapist actively monitors the family's efforts at employing the adaptive solution.

The therapist is mandated to assume an oversight role by the family's agreement about the adaptive solution. The therapeutic mandate is therefore dependent on genuine agreement about the adaptive solution. **If the family has not really accepted the adaptive solution, the therapist's mandate is unclear, and the family may resist interventions because of apparent lack of relevance.**

The stage of solution implementation becomes the central platform for the hierarchical structure of theoretical perspectives and associated interventions. All further interventions are accomplished in order to return to implementing the adaptive solution.

If the family is unable to implement the adaptive solution, the therapist looks for maladaptive patterns in their problem-solving behavior. Once maladaptive patterns are identified, they are brought to the family's attention. The family is then directed to avoid the maladaptive pattern and to learn new adaptive patterns of problem solving. Maladaptive patterns simply may be the result of inadequate information or understanding of behavioral change techniques, or they may be the manifestation of maladaptive formations in the family's structure of roles, boundaries, and distribution of power. **Interventions may be educational (or psychoeducational), behavioral, or structural.**

Educational or psychoeducational interventions might be used to help a family understand and deal better with a disabled member, such as a child with a learning disability or an adult with schizophrenia (Anderson, Hogarty, & Reiss, 1980). **Behavioral interventions might be used to help a family deal with an acting-out child** (Kaye, 1984) or to **help a couple overcome sexual dysfunctions** (Kaplan, 1974). **Structural interventions might be used to help a family with ineffective power distribution across generations** (Minuchin, 1974). The choice of which interventions to use depends on the therapist's assessment of the nature of the maladaptive problem-solving pattern and the family's failure to obtain adequate benefit from earlier interventions.

At this point in the therapy, the therapist begins to form hypotheses concerning the problem maintenance structure. The therapist explores these hypotheses in a hierarchical fashion, ruling out simple and superficial explanations before pursuing more complex explanations. **The primary focus of these initial hypotheses falls on determining the interpersonal function of the problem or symptom.** The therapist investigates the immediate block determinant first and then moves along the continuum toward more remote determinants if the maladaptive patterns persist.

Case Dialogue

Therapist: Good afternoon. It's been a week since we've seen each other. How has it gone? Were there any opportunities for Jack and Mrs. A to discuss Mrs. A's requests?

Mrs. A: Well, I think it's been mixed. Jack was better about not calling me names but he still argued when I asked him to put away the lawnmower, garden tools, hose, and sprinkler. He said it wasn't his job, and when he finally did it, he just dumped the stuff on the floor of the garage.

Therapist: I see, so he did the job but not in a very satisfactory way. What did you do when you found that he had dumped the stuff on the floor of the garage?

Mrs. A: I yelled at him and he yelled at me. He still didn't get everything put away properly; my husband had to do it when he got home.

Therapist: Sounds like we have to define cooperation a little better. Jack, did you feel that your mom listened to you during this interaction?

Jack: All I said was that it wasn't my job. I didn't have to ask if she understood; she knows whose job the yard work is. It's Dad's job.

Therapist: How did you feel about having to do your dad's job?

Jack: I didn't like it; it made me mad.

Therapist: Mad at whom?

Jack: At Mom.

Therapist: All right, this makes me think we need to clarify a couple of points. One is that cooperation means doing the job to your mom's satisfaction. Do you accept that, Jack?

Jack: Yeah, okay.

Therapist: Another is that there needs to be a way for Jack to express his resentment. Mrs. A, is it okay with you if Jack is angry, as long as he still gets the job done?

Mrs. A: I understand his feeling anger, but I won't tolerate what he does with it sometimes.

Therapist: What does he do with it?

Mrs. A: You know—getting hostile, disrespectful, calling me names.

Jack: She yelled at me first. You'd start yelling too if she was yelling at you.

Therapist: You're saying she provoked it. Why did you yell, Mrs. A?

Mrs. A: I guess I was frustrated when I discovered he had just dumped the stuff. I thought we had worked it out. You're going to say I shouldn't yell at him either.

Therapist: Well, I don't think it excuses Jack's behavior. But, yes, these escalations require two parties. I would like you both to make an effort to control your tempers and discuss things rationally. Mr. A, where were you when your wife and Jack had the argument about the gardening tools?

Mr. A: I was at the office. I usually work on Saturdays. I found out about it when I got home that evening.

Therapist: Jack said that the yard work was your responsibility. Is that right?

Mr. A: Pretty much. I enjoy working in the garden and have assumed responsibility for all the outdoor work.

Therapist: So did you leave the tools out in the first place?

Mr. A: Well, I had them out, but it's not like I left them out. I often leave the hose and sprinklers set up and just move them around.

Therapist: Did Mrs. A say anything to you about putting it away?

Mr. A: I don't think so.

Mrs. A: Yes I did. I asked you to put the lawnmower away early in the week because it didn't belong on the patio. You said you'd do it later.

Therapist: So you asked your husband to do it first, but he didn't do it. Then you and Jack got into a hassle over it. How did you feel when Mr. A didn't do it?

Mrs. A: Oh, I know how busy he is. He often forgets little things. I have learned to live with that.

Therapist: And it doesn't make you angry when your husband forgets to do these little things?

Mrs. A: Well, it used to make me mad, but, like I said, I've learned to live with it.

Therapist: What kinds of things do you get angry at your husband for now?

Mrs. A: Well, nothing really. I wish he was around more but.... Sometimes it irritates me that he puts me off so much; he's always got other things that take priority. He's a very busy man.

Therapist: It seems that you have learned to put up with disappointment from your husband, but you won't tolerate it from your son.

Mrs. A: My husband never speaks to me in the tone that my son does!

Therapist: Do you ever speak to your husband in the tone that you use with your son when you are irritated?

Mrs. A: No, my husband never gets me that angry.

RESOLVING INTERPERSONAL BLOCKS:

If direct efforts to implement the adaptive solution are not effective, then the therapist should explore unresolved difficulties between family members. **Blocks at the interpersonal level can stem from conflicts between members or from systemic rules concerning certain behaviors, thoughts, or feelings.** The therapist maintains the mandate while shifting the focus ("defocusing") to these blocks by indicating how the interpersonal dimension is an aspect of the adaptive solution. The underlying premise is that system members must be able to work together effectively to implement the adaptive solution. If they are impeded by unresolved conflicts or prohibited from certain behaviors, thoughts, or feelings, then they are not working together effectively. Working together implies more than simply not interfering with each other; it includes the provision of emotional support.

When the therapist makes the transition to working on interpersonal blocks, there is a change in the communicative process. In general, family members are encouraged

to speak directly to each other rather than about each other to the therapist. During this phase, **the therapist helps the family communicate by asking clarifying questions and acting as a type of referee.** The therapist may need to block excessive expressions of hostility or call a halt to nonproductive lines of discourse. The therapist must carefully track the topic and help the family stay on the subject rather than bring in unrelated grievances or unnoticed topic shifts. **The therapist's goal is to help the family learn to communicate more effectively; he or she makes the family aware of its maladaptive communication patterns and trains family members to recognize them as they occur.**

The therapist can make the transition to the interpersonal level by exploring the quality of "emotional access" across the various relationships. Emotional access can be seen in the expression of both positive and negative feelings (and associated thoughts and behaviors), and includes both affective responsiveness and affective involvement (Epstein & Bishop, 1981). If a relationship is restricted to only one or the other of these feelings, or if the relationship tolerates only a narrow range of feelings, then it is likely that a deficiency in the emotional access exists. If it is the marital/parental relationship that is suffering, it usually follows that there are problems in the child-rearing patterns.

Constrictions in emotional access often are accompanied by catastrophic expectations. Certain thoughts and feelings are not expressed because of fears of what could happen if they were to be expressed. Family members may avoid disagreeing, becoming angry or sad, or being affectionate because they fear the consequences of these actions. It is important to uncover these fears and determine whether they are realistic. Irrational fears can be defused in this way, and validated fears can give the therapist a more precise understanding of the nature of the system and the block(s).

Case Dialogue

Therapist: You say that you never speak to your husband in the angry tone that you sometimes use with Jack. Tell me something. What do you think would happen if you were to get that angry with Mr. A?

Mrs. A: Why, I really don't know.

Therapist: Give me your best guess.

Mrs. A: Well, I suppose if I were to get really very angry, he might just leave.

Therapist: Do you think that you hold back on your anger at Mr. A because inside you fear that he would leave you?

Mrs. A: I don't know. Perhaps.

Mr. A: What has all this got to do with her problem with Jack?

Therapist: I'm thinking that your wife may displace some of her anger at you onto Jack because she is too fearful of getting angry at you directly.

Mr. A: Displace what anger at me?

Therapist: I'm not sure. That's a good question.

Jack: She's angry at you because you're never around. You never want to do anything with us.

Therapist: Jack, you said your dad never wants to do anything with "us." Are you angry at him for never being around?

Jack: Yes. Well, no, not exactly. I'm more perpetually disappointed.

Therapist: Maybe creating problems with your mother serves the purpose of getting your dad involved. Mrs. A, what about what Jack is saying? Are you dissatisfied with how much your husband is around and involved with the family?

Mrs. A: I've always wanted him to be with us more. It used to make me angry, but I've come to expect it.

RESOLVING INTRAPERSONAL BLOCKS:

If problem-solving blocks do not seem to be determined primarily by current interpersonal factors, the therapist should entertain hypotheses about the intrapsychic dynamics of individual members of the patient system. When the therapist defocuses to blocks

at the intrapersonal level, his or her role shifts: The therapist becomes less directive and active, often increasing the use of interpretation and focusing more on the therapist-client relationship. These changes can be experienced by some clients as an abandonment or as blaming. The shift in the therapist's role, along with the associated shift in the expectations of the client(s), should be processed as they occur. In some instances, the therapist may choose to see system members individually or refer them for long-term work with other therapists. **The therapist should make a referral rather than do the individual work personally if he or she feels that excessive involvement with one member will threaten the alliance with the whole system or with other members.**

Blocks at the intrapersonal level include unresolved conflicts from earlier relationships and personality defects that interfere with present functioning. Work on these issues should be accomplished in conjoint sessions whenever possible, because the significant other(s) can share in the insights and provide support to the individual who is temporarily the focus of the therapy. Some intrapersonal work may need to be done in individual sessions because of excessive attacking and scapegoating in the conjoint sessions. However, **the goal of the intrapersonal work is always to facilitate resolution of the interpersonal issues being worked on in the conjoint sessions.**

Defocusing away from the interpersonal to the intrapersonal level again causes a change in the communicative process. The individual is encouraged to become reflective and to report on inner experience. Moreover, the individual is accepted as the best authority on his or her experience, and other family members are not allowed to attack that person's feelings. It can be a time when blaming decreases and understanding increases as individuals are able to "own" their issues.

The transition from interpersonal to intrapersonal occurs in a variety of ways. Perhaps most often, a member will spontaneously bring up historical issues and acknowledge a possible connection with the current interpersonal problem. Pinsof's remote block determinant operation (1983*b*) is a technique for defocusing from the current interpersonal context to the historical. The therapist works with an individual to heighten his or her awareness of his or her affective reaction to the problematic situation under discussion and asks the individual to think back to the first time he or she ever felt the way he or she is now feeling. **An important aspect of this operation is that the therapist establishes a clear distinction between the current interpersonal discussion and the sudden request to think back beyond the current relationship.**

Working at the interface between the intrapersonal and interpersonal levels often results in family members developing a better awareness of how their current feelings are influenced by transferences. **This component of the work emphasizes the individual's responsibility for changing his or her current behavior after the development of insight.** But change is also sought among the other family members, who should understand the individual better and be able to respond to him or her in a more adaptive way. Thus, all family members retain responsibility for change.

Case Dialgoue

Therapist: Mr. A, were you aware that your family wanted you around more?

Mr. A: I've always known that my wife wanted me home more. I have a very demanding career. It doesn't give me a lot of free time.

Therapist: From what Jack was saying, it sounds like you aren't very available even when you are home.

Mr. A: I'm pretty tense when I come home. I need time alone to wind down. I always have. That's why I like working in the garden.

Therapist: What happens when you do spend time with the family? Do you enjoy it?

Mr. A: It's okay. We have a nice life.

Therapist: Do you come from a family that spent a lot of time together?

Mr. A: No more than average. My dad was gone a lot. He was generally upset about something when he was around.

Therapist: What do you mean?

Mr. A: My dad was very critical. I liked not having him around because he was always down on either me or my mom. And they fought a lot. It was not much fun to be around.

Therapist: Did you fight with him?

Mr. A: No, I didn't stand a chance against him.

Therapist: So what did you do?

Mr. A: I just stayed out of his way as much as possible. I left home at 17 and never went back, except for short visits.

Therapist: Are you doing the same thing now?

Mr. A: What do you mean?

Therapist: Are you staying away from the home to avoid conflict?

Mr. A: It's certainly no fun to be around when the two of them are going at it.

Therapist: Perhaps you avoid closeness with your wife because you don't want to get into a situation where you can be easily hurt by her criticism—as you were by your father'. .

Mr. A: I don't know about that.

Mrs. A.: When we have a disagreement, you always tell me I'm being too critical.

Therapist: It seems that your wife is afraid to express her anger at you for fear you'll leave, and you're afraid to get close to her for fear she'll hurt you with her criticism. But the less you are around, the more angry she gets, and then turns it on Jack. And the more Mrs. A fights with Jack, the less you want to be around because the result is a conflictual home like the one you escaped. You're caught in a vicious circle.

Mrs. A.: How do we get out of it?

Therapist: Well, you have to learn to express your displeasures directly to your husband—despite his fear of criticism. And, Mr. A, you have to take a chance and get more involved with your family. And Jack has to learn to be more cooperative and express his displeasures in an acceptable fashion. This coming week, I would like to focus again on Jack and Mrs. A learning to interact more respectfully. But I would also like to have Mr. A more available to Mrs. A. Now, how can we go about arranging that?

The Therapeutic Alliance

Bordin (1979) recommended viewing the therapeutic alliance in terms of the tasks, bonds, and goals of the therapy. To foster a positive alliance, the therapist and client must be in agreement about the goals, the therapeutic tasks must be accepted by the client as relevant, and a bond between the therapist and the client must be present. Although Bordin's model was developed for an individual therapy paradigm, the same conditions apply in family therapy; but they become more complicated due to the potential for multiple alliances. **Family therapists have an alliance with each individual as well as with the entire system.** Thus, **alliance with one individual may threaten the alliance with another** (Pinsof & Catherall, 1986). Usually, families are struggling actively with problems and place a greater demand on the therapist to do something than do many individual clients. The intensity of the demand and the fertile ground for countertranference reactions make family therapists especially vulnerable to bringing their own issues into the therapy; they need structure to guide their interventions (Catherall & Pinsof, 1987).

The problem-centered model is designed to maintain the best possible therapeutic alliance throughout treatment. It clearly defines when to explore the interpersonal and intrapersonal dimensions, and it

gives the therapist a mandate that can extend into remote areas of a patient's life. The therapist establishes the relevance of these explorations by showing how the failure to employ the adaptive solution is linked to the interpersonal dimension, and how intrapersonal issues interfere with interpersonal functioning. Thus, the problem-centered orientation maintains a clear agreement about the goals of the therapy and establishes the relevance of therapeutic tasks.

The bond dimension of the alliance develops as a result of the therapist's respect for all family members and the therapist's focus on feelings. The model defines the expression and use of feelings as an important aspect of adaptive problem solving. The bridge to the interpersonal level is often the nonexpression of important feelings between system members. When the therapist inquires about with whom an individual shares his or her feelings, the underlying assumption is that this affective communication is an integral aspect of dealing with the problem. The therapist's attention to feelings and respect for the individual contribute to the development of a positive bond with each family member and with the family as a whole.

Conclusion

In the problem-centered model of interviewing, **the therapist's task changes as the stages of the model unfold.** After establishing agreement about the nature of the problem and the appropriate adaptive solution, the therapist first intervenes by **educating the family** and **directing the appropriate behaviors to resolve the problem.** If these efforts are not sufficient, **the therapist assumes more of a referee role as the family is helped to interact and resolve their interpersonal issues. If the interpersonal issues are influenced by significant individual psychopathology, the family interacts less and the therapist becomes more centrally involved with the individual family members.**

The therapist conducts the therapy so that it evolves through these stages as he or she tests hypotheses about the problem maintenance structure. The therapist must be able to propel the family system from one stage to another through techniques such as exploring the emotional access in the interpersonal system and exploring the transference origins of interpersonal issues. The therapist also must be alert to family reactions to the changes in his or her role (e.g., increases and decreases in directiveness), and must help the family process these changes so they do not interfere with the therapeutic task.

Finally, **although the model was presented in a linear fashion, the reader is not obligated to move in the direction presented in this lesson.** As intrapsychic and interpersonal issues are resolved, the therapist may become more active in helping the family make renewed attempts at implementing the adaptive solution. As adaptive solutions are effectively implemented, newer problems may emerge, leading the therapist again to pursue interpersonal and intrapsychic hypotheses and interventions.

REFERENCES

Anderson, C. M., Hogarty, G. E., & Reiss, D. J. (1980). Family treatment of adult schizophrenic patients: A psycho-educational approach. *Schizophrenia Bulletin, 6,* 490–505.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the therapeutic alliance. *Psychotherapy: Theory, Research and Practice, 16,* 252–260.

Catherall, D. R., & Pinsof, W. M. (1987). The impact of one's personal family life on the ability to establish viable therapeutic alliances. *Journal of Psychotherapy and the Family, 3*(2), 135–160.

Epstein, N. B., & Bishop, D. S., (1981). Problem-centered systems therapy of the family. In A. Gurman & D. Kniskern (Eds.), *Handbook of family therapy* (pp. 444–482). New York: Brunner/Mazel.

Epstein, N. B., Bishop, D. S., & Levin, S. (1978). The McMaster model of family functioning. *Journal of Marital and Family Therapy, 8,* 295–308.

Feldman, L. B., & Pinsof, W. M. (1982). Problem maintenance in family systems: An integrative model. *Journal of Marital and Family Therapy, 8,* 295–308.

Kaplan, H. S. (1974). *The new sex therapy.* New York:Brunner/Mazel.

Kaplan, H. S. (1979). *Disorders of sexual desire and other new concepts and techniques in sex therapy.* New York: Brunner/Mazel.

Kaye, K. (1984). *Family rules: Raising responsible children.* New York: Walker.

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

Pinsof, W. M. (1981). Symptom/patient defocusing in family therapy. In A. Gurman (Ed.), *Questions and answers in the practice of family therapy* (pp. 50–56). New York: Brunner/Mazel.

Pinsof, W. M. (1983a). Integrative problem-centered therapy: Toward the synthesis of family and individual psychotherapies. *Journal of Marital and Family Therapy, 9*(1), 19–35.

Pinsof, W. M. (1983*b*). The marital-relational defocusing operation: The remote block determinant operation. Unpublished manuscript. Center for Family Studies/The Family Insititute of Chicago.

Pinsof, W. M., & Catherall, D. R. (1986). The integrative psychotherapy alliance: Family, couple, and individual therapy scales. *Journal of Marital and Family Therapy, 12*(2), 137–151.

Sluzki, C. E. (1978). Marital therapy from a systems theory perspective. In T. J. Paolino & B. S. McCrady (Eds.), *Marriage and marital therapy: Psychoanalytic, behavioral and systems theory perspectives* (pp. 366–394). New York: Brunner/Mazel.

Questions Based On This Lesson

1. Consider the following question by a therapist:

   "Mr. B., are you aware when Mrs. B. feels upset about this problem?"

   In which step in the intervention structure is the therapist engaging?

   A. Resolving intrapersonal blocks

   B. Developing solutions

   C. Identifying the problem

   D. Resolving interpersonal blocks

2. Which of the following does the author *not* advocate when attempting to identify the problem in the intervention stucture?

   A. Each family member gives his or her opinion of the problem

   B. The therapist ensures that family comments are specific

   C. The therapist ensures that family members who seem to be wronged are especially supported

   D. Each family member explains what he or she has done to try to solve the problem

3. According to the author, which of the following is an important characteristic of family therapy?

   A. A nondirective, passive style

   B. Focus on resolution of a specific problem

   C. The enhancement of self-actualization for all family members

   D. Focus on increasing self-understanding and personal growth

4. With which of the following statements would the author agree?

   A. Interpersonal conflicts are impossible to solve without first alleviating each family member's intrapersonal conflicts.

   B. The main goal of family therapy should be to help each family member realize that the requirements of the family system take precedence over any individual's needs.

   C. In problem-centered family therapy, it is critical always to progress through the following steps in order: identifying the problem, developing solutions, implementing solutions, resolving interpersonal conflicts, and resolving intrapersonal conflicts.

   D. None of the above

Directions in Marriage and Family Therapy © 1994, The Hatherleigh Company, Ltd.
All rights reserved. Not to be reprinted without permission of the publisher.

Special Program Coordinators: Dennis A. Bagarozzi, PhD Frederic Flach, MD

Editorial Board of Consultants: James Alexander, PhD; Stephen Anderson, PhD; Judith I. Bagarozzi, MS; Insoo Kim Berg, MSSW; William J. Doherty, PhD; Craig Everett, PhD; Charles Figley, PhD; Alan S. Gurman, PhD; Harvey Joanning, PhD; Florence Kaslow, PhD; James F. Keller, PhD; Luciano L'Abate, PhD; Pieter le Roux, PhD; Howard Liddle, PhD; Mel Markowski, PhD; Fred P. Piercy, PhD; Lynda Dykes Talmadge, PhD

Managing Editor: Debra E. Cermele

Associate Editor: Steven L. Pessagno

Directions in Marriage and Family Therapy is a continuing education program published by The Hatherleigh Company, Ltd., 420 East 51 Street, New York NY 10022. For additional information, please call 800-367-2550 or 212-355-0882 (outside the US).

Directions in Marriage and Family Therapy

VOLUME 2 • LESSON 2

Identification, Assessment, and Treatment of Women Suffering from Post-Traumatic Stress After Abortion

Dennis A. Bagarozzi, PhD

Dr. Bagarozzi is President of Georgia Preferred Inc, and is in private practice in Atlanta, GA, and Athens, GA.

This lesson is adapted with permission from: Bagarozzi, D. A. (1994). Identification, assessment, and treatment of women suffering from post-traumatic stress after abortion. Journal of Family Psychotherapy, *5(3), 25–54.*

KEY POINTS

- Delayed response to severely upsetting life experiences characteristic of post-traumatic stress disorder (PTSD) occurs in a small percentage of traumatized persons.

- Denial is seen as a major contributing factor to the development of post-traumatic stress in women who have had an abortion.

- The appearance of any of the following symptoms should alert the therapist of possible PTSD: flashbacks of the surgical procedure, people involved, or surroundings; nightmares of being trapped in a man-made disaster and being unable to help others who are suffering; participating in or witnessing a terroristic act, ritual murder, or human sacrifice; sadomasochistic interactions or accident proneness where the client receives punishment or pain designed to alleviate feelings of guilt; sexual dysfunctions with no physiologic basis; emotional outbursts, temper tantrums, or feelings of rage; psychosomatic symptoms; or impacted grief reactions.

- The resolution of PTSD usually does not require long-term treatment, but no systematic follow-up studies have been conducted.

- The percentage of women who suffer from post-traumatic stress disorder as a result of having had an abortion is unknown. Empirical research on this issue is sorely needed.

Introduction

In a recent article, Bagarozzi (1993) described a sample of 18 women who sought marital/sex therapy presenting a symptom complex characteristic of persons suffering from post-traumatic stress disorder (PTSD). Detailed assessment revealed that *abortion was the single traumatic life event shared by all of these women.* **The delayed response to severely upsetting life experiences characteristic of PTSD occurs in a small percentage of traumatized persons** (Blank, 1982). However, most victims appear to have been fully aware and conscious of their distressed, anxious, frightened, or repulsed reactions at the time of the traumatic occurrence or shortly thereafter. **What was very different about the women in the Bagarozzi (1993) sample was their complete denial that undergoing the abortion was indeed a traumatic and horrific experience for them.**

This denial was seen as a major contributing factor to the development of post-traumatic stress in these women. Therefore, understanding the dynamics of unconscious denial and other key intrapsychic defenses and how they served to maintain intrapersonal equilibrium and interpersonal homeostasis is seen as crucial to the successful treatment of these women and their relationships with their husbands/partners, men in general, and significant others in their lives. Furthermore, **identification and understanding of how intrapsychic defenses and personal life themes combine with conjugal defenses** (e.g., unconscious collusion, complementary projective indentifications, reciprocal acting-out, splitting and coalition maintenance, alternating patterns of scapegoating and sado-masochistic cycles of dominance and reconciliation) **to create marital (dyadic) "sub-myths" that *keep the trauma repressed* is essential for helping couples and individuals work through the unresolved issues related to past abortions.**

It is important to understand that some clients, even when questioned directly during the assessment about past abortions, may consciously deny having had an abortion. Others may admit to having terminated a pregnancy, but they unconsciously deny its impact and significance. In such cases, **the appearance of any of these symptoms should alert the therapist to the possibility of a delayed stress reaction: (a) Flashbacks of the surgical procedure, people involved, or the physical surroundings; (b) nightmares of being trapped in a man-made disaster and being unable to help others who are suffering, or participating in or witnessing a terroristic act, ritual murder, or human sacrifice; (c) the sudden onset of sadomasochistic interactions or accident proneness where the client receives punishment or pain designed to alleviate unconscious feelings of guilt; (d) sexual dysfunctions having no physiologic basis; (e) uncharacteristic emotional outbursts, temper tantrums, or episodes of rage; (f) the sudden onset of psychosomatic symptoms; and (g) impacted grief reactions.**

This lesson provides a detailed case study designed to illustrate a number of clinical issues relevant to the treatment of a couple for whom unresolved issues concerning abortion play a central role.

Assessment

Mr. and Mrs. Marks contacted their therapist for an appointment to discuss the future of their marriage. Mrs. Marks had revealed to her husband that she had just ended an affair that had lasted 18 months. This revelation was the precipitating factor that brought the couple in for consultation. During the initial interview, **an extensive history of the presenting problem and of the couple's relationship was taken. An assessment of the couple's communication patterns, problem-solving style, conflict-ne-**

gotiation strategies, and goal-setting abilities was also conducted (Bagarozzi & Anderson, 1989).

At the conclusion of the initial interview, the couple was given the following instruments to complete: Locke-Wallace Marital Adjustment Test (Locke & Wallace, 1959); Spousal Inventory of Desired Changes and Relationship Barriers—SIDCARB (Bagarozzi, 1983); IMAGES of the Ideal Spouse (Anderson, Bagarozzi, & Giddings, 1986); Family Adaptability and Cohesion Scales—FACES III (Olson, Portner, & Lavee, 1985), Personal Authority in the Family Systems Questionnaire—PAFS-Q (Bray, Williamson, & Malone, 1984); Intimacy Needs Survey (Bagarozzi, 1990). ***Prior to leaving the first interview, the couple was given three behavioral tasks to complete: a problem-resolution task, a conflict-negotiation assignment, and a goal-setting task.*** *The results of these assessments are presented below.*

LOCKE-WALLACE MARITAL ADJUSTMENT TEST:

Scores on this measure of marital adjustment and satisfaction were 58 for Mrs. Marks and 88 for Mr. Marks. These scores place the couple in the dysfunctional/dissatisfied range.

IMAGES OF THE IDEAL SPOUSE:

Discrepancy/difference percentage scores between one's ideal spouse and one's perceived spouse fell in the moderate range for both Mrs. Marks (D=21%) and Mr. Marks (D=-28%), indicating that some clinical work designed to help both spouses work through their ideal/perceived discrepancies was in order.

SIDCARB:

This instrument is designed to **assess two critical dimensions of the social exchange process between spouses.** The first empirically derived factor assesses the extent to which each spouse perceives the conjugal exchange process to be fair and equitable. Raw scores are transformed into standard scores that have a mean of 50 and a standard deviation of 10. **The higher the score, the more inequitable the exchange process is perceived to be by the respondent, and the more change he or she desires in his or her mate's exchange behavior. As scores increase on this factor, marital satisfaction decreases.**

Factors II and III of SIDCARB assess barriers to terminating an unhappy marriage. Factor II is a measure of internal psychological barriers to relationship termination (e.g., commitment to one's marriage vows, obligations to one's children, religious beliefs, concerns about one's relatives' reactions). Factor III is a measure of external circumstantial barriers to divorce (e.g., job considerations, legal costs, financial concerns, responses of friends and neighbors).

SIDCARB scores for Mr. Marks were 69 (factor I), 39 (factor II), and 38 (factor III). For Mrs. Marks, they were 77 (factor I), 39 (factor II), and 59 (factor III). **These scores show that both Mr. and Mrs. Marks are extremely dissatisfied with the social exchange process in their marriage.** Both spouses desire a considerable amount of change. Internal psychological barriers to divorce are low for both Mr. and Mrs. Marks, but a significant difference in external circumstantial barriers between the spouses is evident. Whereas Mr. Marks perceives little external constraint, Mrs. Marks sees some impediments to divorce (i.e.,legal costs and financial concerns). Mr. Marks wields slightly more power in this marriage by virtue of his perceiving fewer barriers to relationship termination (Bagarozzi, 1983, 1991; Waller & Hill, 1951).

FACES III:

Perceived ideal discrepancies on this measure of: marital closeness (cohesion) and structure (adaptability)

were identical for this couple. **Both perceived their relationship to each other as chaotically separated**; both desired the ideal of being flexibly connected. For a more comprehensive appraisal of where intimacy had broken down in this couple's relationship, the Intimacy Needs Survey (Bagarozzi, 1990) was employed.

INTIMACY NEEDS SURVEY:

The Intimacy Needs Survey was developed to help spouses pinpoint those areas of intimacy in which they feel unfulfilled. This clinical tool asks spouses to evaluate their satisfaction with eight separate dimensions of intimacy: emotional, psychological, intellectual, sexual, spiritual, aesthetic, social-recreational and physical (nonsexual) intimacy. Three scores are calculated for each dimension: (1) need strength (range, 1–100), (2) satisfaction percentage with a spouse's receptivity to one's felt and expressed need and (3) satisfaction percentage with the spouse's reciprocal disclosures in each need area. Reciprocal disclosure scores are computed for the first six areas of intimacy. Only two scores (need strength and satisfaction with a spouse's receptivity to each of these needs) are computed for social-recreational intimacy and physical intimacy. Major differences in need strengths and satisfactions were found for Mr. and Mrs. Marks. Their scores are presented in Table 1.

From the data presented in Table 1, we can see that Mrs. Marks has a stronger need for intimacy than does her husband. Scores that fall below the 70% mark in either receptivity satisfaction or reciprocity satisfac-

Table 1
INTIMACY NEEDS SURVEY SUMMARY SCORES: PRE-TREATMENT AND POST-TREATMENT COMPARISONS

Need		*Mr. Marks*		*Mrs. Marks*	
		Pre	*Post*	*Pre*	*Post*
Emotional	Strength	54	60	81	85
	Receptivity satisfaction	100%	100%	55%*	75%
	Reciprocity satisfaction	75%	100%	50%	75%
Psychological	Strength	63	68	49	52
	Receptivity satisfaction	75%	80%	71%	85%
	Reciprocity satisfaction	75%	90%	43%*	75%
Intellectual	Strength	72	73	64	65
	Receptivity satisfaction	75%	78%	86%	87%
	Reciprocity satisfaction	75%	81%	75%	80%
Sexual	Strength	63	70	81	86
	Receptivity satisfaction	14%*	75%	22%	65%
	Reciprocity satisfaction	13%*	75%	22%*	65%
Spiritual	Strength	63	63	81	80
	Receptivity satisfaction	14%*	75%	44%*	75%
	Reciprocity satisfaction	14%*	78%	57%	80%
Aesthetic	Strength	54	52	72	70
	Receptivity satisfaction	100%	100%	33%	80%
	Reciprocity satisfaction	100%	100%	43%*	75%
Social/ Recreational	Strength	49	53	72	78
	Receptivity	43%*	80%	44%	67%
Physical	Strength	49	51	100	100
	Receptivity	100%	100%	70%	85%
Total Need	**467**	**490**	**600**	**617**	

** Indicative of a problematic area*

tion are considered to be problematic. Mrs. Marks is dissatisfied with six out of the eight areas of intimacy assessed by this measure. Mr. Marks shows dissatisfaction in only three areas.

PAFS-Q:

The PAFS-Q consists of eight factor-derived subscales. The PAFS-Q profiles for Mr. and Mrs. Marks are shown in Table 2.

The PAFS-Q profile for Mr. and Mrs. Marks is quite revealing. Again, **we see low levels of intimacy between spouses as well as between each spouse and his or her family of origin**. Mr. Marks shows a considerable degree of dysfunctional (triangulated) involvement with his parents. **Mrs. Marks appears to be free from triangulation, but her high score for intergenerational intimidation and her low score for personal authority are indicative of a person who has resorted to a defensive "emotional cutoff" to deal with unresolved issues of separation-individuation** (Anderson & Sabatelli, 1990). Essentially, Mr. and Mrs. Marks show PAFS-Q scores that are found to be typical of persons who have failed to separate and individuate from their families of origin.

Table 2
PAFS-Q SUBSCALES

	Mr. Marks	*Mrs. Marks*
1. Spousal Intimacy	Low	Low
2. Spousal Fusion	Low	Low
3. Intergenerational Intimacy	Low	Low
4. Intergenerational Fusion	Low	Low
5. Nuclear Family Triangulation	High	Low
6. Intergenerational Triangulation	High	Low
7. Intergenerational Intimidation	Low	High
8. Personal Authority	High	Low

Such failure makes it very difficult to establish intimacy with one's spouse (or partner).

Communication Patterns, Conflict-Negotiation Strategies, Problem-Solving Styles and Goal-Setting Abilities

Two stable relational-communication patterns (Ericson & Rogers, 1973) **were found to be characteristic of this couple's interactions: (1) A rigid complementary style with Mrs. Marks in the dominant, one-up position, and (2) periodic symmetrical escalations taking the form of intellectual debates initiated by Mr. Marks. Neither pattern resulted in successful problem solving and conflict negotiations**. Typically, the couple became deadlocked in various unresolvable conflicts. Goal-setting attempts, in the form of "planning something together," appeared to be successful at first, but the actual follow through failed to occur unless Mrs. Marks took the major responsibility for carrying out the agreed-upon outcome. This failure to work cooperatively as a team pervaded the Marks' relationship.

Couple Relationship History and History of the Presenting Problem

Mr. and Mrs. Marks met in a singles bar 6 weeks after Mrs. Marks had had her abortion. He asked her for her telephone number and then called her later in the week for a date. Mr. Marks recalled that it took all his courage to initiate this second contact with Mrs. Marks. Mrs. Marks said that she was, at first, unimpressed with Mr. Marks. He was "just another guy" who was interested in "getting into my pants." Her attitude changed, however, when she found that Mr. Marks was not about to chase after her and "fall all over himself trying to get

me into bed." When she told him that she did not know whether she would go out with him because she did not know what other options were available to her for the weekend, Mr. Marks responded that he had no intention of waiting around for her. Fearing the possible rejection and not wanting to be ignored, Mrs. Marks agreed to go out with Mr. Marks. From that time onward, Mrs. Marks took responsibility for continuing their relationship by pursuing Mr. Marks.

Their courtship was brief and the couple was married as soon as Mrs. Marks graduated from college, 4 months after their initial meeting. Shortly after their honeymoon, Mr. Marks was transferred to a distant Midwestern city. Mrs. Marks did not travel with him and remained in their apartment so that she could continue pursuing her new career. Neither spouse saw any reason for Mrs. Marks to relocate with her husband since Mr. Marks' transfer was supposed to be temporary. However, Mr. Marks found himself in this new position for close to 2 years. Both agreed that if their marriage was to succeed, the commuting had to end. Mr. Marks left his position for a lower paying one so that he could rejoin Mrs. Marks. Shortly after the couple reunited, Mrs. Marks lost her job. Since Mrs. Marks was no longer employed and the couple was unable to maintain its accustomed standard of living, Mr. Marks applied for and obtained a higher paying management position in his home town. The couple then moved to the South.

It initially seemed that the couple could finally settle down and raise a family, but Mr. Marks' new position required that he work late almost every evening. Mrs. Marks said that she found herself "four-and-a-half years into a marriage where there was no intimacy." **Her attempts to initiate intimate conversation with her husband seemed fruitless**. A turning point in her relationship with Mr. Marks came one evening when she attempted to discuss with him her desire to have a child. During this conversation, **Mrs. Marks became overwhelmed with emotion and she disclosed that she had had an abortion during her senior year in college. She tried to explain to him how guilty and ashamed she felt, how she had been carrying around this burden for years, and how much having a child would mean to her.** As she talked, Mr. Marks sat silently, listening attentively. When she regained her composure, he said that he did not think that this was the time to start a family. **Neither the abortion nor Mrs. Marks' feelings about her abortion were addressed by Mr. Marks**. Shortly after this incident, Mrs. Marks began her affair with a man that she felt was able to meet her intimacy needs and "share her pain."

Personal History and History of Family Relationships

Mr. Marks was the first son born to an alcoholic civil servant. Mr. Marks described his father as a depressed loner who was unavailable to the family. His mother was portrayed as an intrusive and aggressive businesswoman who had little respect for her husband. Early in life, Mr. Marks learned to "keep out of my mother's way" and not to "bother" his father. With the birth of his younger brother when Mr. Marks was 5 years old, his mother's attentions were turned toward her new son. This allowed Mr. Marks to "get out from under the gun." At home he learned how to go about his business without bringing attention to himself. **By the time Mr. Marks entered high school, he had perfected an interpersonal style that is best described as "nonintrusive." Like camouflage, Mr. Marks learned how to blend in with his surroundings**. Mr. Marks characterized himself as a "late bloomer" who was afraid to approach girls. His first date came about when an older girl from a neighboring school asked him to take her to the senior prom. At the

close of the evening, his date became "sexually aggressive." She began to kiss, fondle, and undress Mr. Marks. Intercourse followed, and Mr. Marks left his first date "in a wonderful state of shock." He continued to date this girl for more than 2 years until she became pregnant. The news of her pregnancy shocked him, because he had been led to believe that she had been using birth control pills. He was even more shocked when she told him that she had arranged for an abortion and that she would not be seeing him again. Their relationship ended as abruptly as it had begun. This experience with his first girlfriend became the prototype for future love relationships. Women would initiate the romance and then terminate their association with Mr. Marks.

In Mr. Marks' junior year of college, his younger brother died of a drug overdose. **Just as his family had denied his father's alcoholism, his brother's drug problem had never been acknowledged.** After his brother's funeral, Mr. Marks' father's drinking increased. Neither he nor his parents ever discussed his brother or his tragic death again.

MRS. MARKS:

Mrs. Marks came from a military family. She respected but feared her stoic father, a commissioned officer, whom she described as a self-centered, aloof man who possessed a sharp tongue and a sardonic sense of humor. Her brother, 5 years older than her, was characterized as "cut from the same cloth" as his father.

Mrs. Marks said that no matter how hard she tried, she rarely got any praise or recognition from her father. She was an excellent student in high school, captain of the cheerleading team, and earned varsity letters in several sports. However, these accomplishments went unnoticed until she called her parents' attention to them. **Early in life, Mrs. Marks found that she could attract her parents' attention, if only for a short time, if she engaged in behavior that was considered to be atypical for girls.** She said that she spent most of her preadolescence being a tomboy. Later, in high school, she learned that she could get her parents' attention if she became involved in dangerous activities (e.g., competitive high diving, white water canoeing, rockclimbing, and rappeling). However, these sports attracted only passing notice as did her earlier exploits as a tomboy.

Mrs. Marks had always been an attractive girl, but her exceptional looks brought only ridicule from her father, who said that she attracted boys like "shit attracts flies." Needless to say, such a characterization only contributed negatively to her already low self-esteem. Mrs. Marks believed that if anyone *really* knew her true self, he or she would ultimately reject her. As a result, a serious internal conflict arose between Mrs. Marks' intense need not to be ignored (which pushed her toward people) and the fear of her true self being discovered (which caused her to withdraw from true intimacy).

Several weeks before Mrs. Marks was to leave for college, her parents arranged for her to see a gynecologist so that she could get a prescription for oral contraceptives. Mrs. Marks was both hurt and surprised by this. She protested that she was a virgin and had planned to remain so until she was married. Her parents dismissed this as "irresponsible." Her father insisted that she comply with their request. Tearfully, she agreed to meet with the gynecologist but secretly vowed not to use birth control.

During her junior year, she moved in with a man. Although this was a significant event for Mrs. Marks, her parents seemed to take it as a matter of course. It was "no big deal to them." Although the man with whom she was living proposed marriage on a number of occasions, Mrs. Marks declined. During her senior year, she became pregnant. She was furious with her lover, because she believed he had willfully neglected to use a condom in order to impregnate her so that she would be forced to

marry him. Her response to his offer to marry her was to have an abortion. She returned to her parents' home to finish out her senior year. **Although her depression and anxiety were obvious to her parents (she cried daily for a period of weeks after her abortion), neither parent asked her what was troubling her. Finally, she could no longer tolerate the guilt she was feeling, and she told both parents that she had had an abortion. They showed little emotion. They simply said that she had done the "right thing" and that she "should not feel guilty." The incident was dropped, and Mrs. Marks never talked about her abortion again until she attempted to discuss the experience with her husband. Her parents' response to her abortion further confirmed her feelings of rejection and worthlessness. She remarked, "Nothing I do or produce is worth very much—not even my child has any worth."**

Relevant Themes From the Personal Mythologies of Both Spouses

One's personal mythology comprises a system of loosely tied together thematic beliefs about the self, the self in relation to others, human nature (in general) and one's unique place in the cosmos. Personal myths serve the function of explaining and guiding human behavior in a manner similar to the role played by cultural and religious myths in all societies. They give meaning to the past, establish personal continuity, define the present, and provide direction for current and future actions. Personal myths allow people to organize experiences in ways that give them psychological meaning and significance (Anderson & Bagarozzi, 1983, 1989; Bagarozzi & Anderson, 1982, 1989).

The themes that make up an individual's personal mythology are finite. However, themes are by no means static. **They evolve and change with the passage of time. Personal themes exist at various levels of awareness. Some are fully conscious; others are totally unconscious. Some serve stabilizing functions in one's life; others promote growth, change, and development. The functionality or dysfunctionality of any theme in a person's mythology can be determined by assessing the degree to which it contributes to or curtails individual development, personal growth, self-realization and self actualization.**

Outlined below are the personal themes, for each spouse, that were thought to be relevant for understanding and treating the couple's presenting problem.

MR. MARKS:

Theme I

The consequences of my attempts to establish interpersonal closeness and intimacy are unpredictable. Trying to get close to some people is frustrating, if not impossible (i.e., my father). Getting too close to others, on the other hand, can be frightening, because closeness to such people may threaten personal integrity and autonomy (i.e., my mother).

> *Lifestyle Solution:* Being a "camouflage man" is a protection that allows me to become involved with people yet remain at a safe distance.

Theme II

Openly declaring my love, affection, or concern for another person ultimately will lead to rejection, abandonment, or death. I loved my brother, and tried to help him with his drug problem, but he refused my help (rejection) and died from an overdose of heroin (abandonment and death). I loved my first girlfriend, but she left me (rejection and abandonment) and had an abortion (death).

> *Lifestyle Solution*: I must never allow myself to feel or experience strong positive feelings for anyone. If I do experience such strong loving emotions, I must conceal them—keep them to

myself and never become emotionally dependent upon anyone. Not showing my true emotions of love and need will protect me from rejection, abandonment, and the ultimate loss death of a loved one. You can't lose what you never had!

MRS. MARKS:

Theme I

Important people (e.g., my parents and brother) ignore me and fail to recognize my accomplishments unless I call attention to myself and what I have accomplished, or if I do something atypical for my sex or dangerous.

Lifestyle Solution: In my relationships with people that are important to me, I must continually find ways to draw attention to myself so that I am not ignored or go unnoticed. I am one of very few women in my profession who is successful. This brings me a lot of recognition professionally but does not bring me any recognition from my family or from my husband. Therefore, I must continue to engage in behaviors that are atypical for women or dangerous in order to draw attention to myself.

Theme II

On the surface, I am a beautiful and attractive woman. Inside, however, I am worthless, dirty and ugly. Men are attracted to me because of my good looks, but they really don't know the real me who is rotten to the core.

Lifestyle Solution: **I must never let anyone, especially a man, see the real me, because if anyone sees the real me, he or she will be repulsed.** I have learned that if I give men what they want—sex—they will not ignore me, and I will never have to show them my true rotten self. I don't really enjoy sex. It only makes me feel more dirty and ugly, but it serves to keep men coming back—yet it keeps them from knowing the real me.

Theme III

I have been keeping a terrible secret and have been carrying around a very heavy burden of shame and guilt. I had an abortion in college and this only contributed to my feelings of low self-worth, badness, and ugliness.

Lifestyle Solution: **I must find a way to unburden myself of these terrible feelings of shame and guilt about my abortion. I must find a man who will help me feel better about myself and what I have done—a man who will accept the real me and give me another child to replace the one I aborted.**

Relationship Between Personal Mythologies and the Presenting Problem

The logical link between individual dynamics and marital dynamics is seen in the interlocking of the personal themes between spouses. This dovetailing of two distinct sets of themes forms the basis of a couple's mythology.

An important aspect of the process and the subsequent stabilization of the couple's relationship is believed, by many clinicians, to be the nonverbalized and unconscious expectations held by both spouses; i.e., their mates will help them resolve long-standing personal problems and interpersonal issues by playing out corrective thematic roles and scripts from their respective personal mythologies (Bagarozzi & Anderson, 1989; Byng-Hall, 1973; Dicks, 1967; Lewis & Spanier, 1979; Lidz, Cornelison, Fleck, & Terry, 1957; Sager, 1976; Satir, 1967; Wgmbolt & Wolin, 1987; Wynne, Ryckoff, Day, & Hirsch, 1958).

When Mr. Marks met his wife-to-be, he perceived her as a fairly independent woman who would not push for a degree of interpersonal closeness that threatened him. Essentially, she was a woman who would not demand that he make significant changes in his behavior, who would take the major responsibility for their sexual relationship, who would tend to their relationship's development (a

continuation of the pattern that had characterized Mr. Marks' previous relationships with women) and who would not make demands upon him to declare his love for her openly (i.e., he did not have to risk rejection and abandonment).

It appears that from the very outset of this couple's relationship (i.e., Mr. Marks' telephone call to Mrs. Marks), Mr. Marks unknowingly activated a central theme in Mrs. Marks' personal mythology (i.e., fear of being ignored). As a counter measure, Mrs. Marks resorted to her customary lifestyle solution: She seduced Mr. Marks and began to take responsibility for their sexual relationship. Her behavior was very familiar to Mr. Marks and fit well into his characteristic way of relating to women. However, as their relationship progressed, the theme of intimacy and interpersonal closeness causing anxiety was triggered in Mr. Marks. This triggered his typical defensive lifestyle solution to the unpredictability of intimacy; i.e., he withdrew into his "camouflage man" behavior. Unfortunately, Mrs. Marks felt her husband was ignoring her, and she consequently pursued him further. The more she pursued, the more he withdrew; the more he withdrew, the more she pursued.

When circumstances beyond their control forced Mr. and Mrs. Marks to live apart, Mr. Marks was able to obtain the physical and emotional distance from his spouse that he needed in order not to feel threatened by intimacy. However, Mrs. Marks interpreted her husband's satisfaction with their living arrangements as a confirmation of her worthlessness and unimportance. This caused her to escalate her attention-getting behaviors. As she had done as a child, she tried to call attention to herself by taking up dangerous "male"-oriented sports (i.e., stock car racing and Bunge jumping). Instead of these activities causing Mr. Marks to pay more attention to his spouse, they alarmed Mr. Marks and activated his fears of abandonment, death, and loss. Mr. Marks' typical lifestyle solution for dealing with the threat of abandonment and loss (i.e., not to show any emotions) was perceived by Mrs. Marks as her husband's ignoring her and not caring for her.

In a desperate attempt for validation, Mrs. Marks disclosed her painful secret. However, this revelation brought only "more of the same" behavior from Mr. Marks, who withdrew even further because this new information served to exacerbate his anxiety about death, loss, and abandonment; also, it reactivated his own guilt and shame about his high school sweetheart's abortion. Mr. Marks' retreat from his wife's solicitations was the "last straw" for Mrs. Marks, who interpreted his withdrawal as proof that she indeed was a "pile of shit."

Mrs. Marks had hoped that by marrying Mr. Marks she might be able to relive, rework, and bring to a successful resolution a number of dynamic conflicts from her past (e.g., complete the separation-individuation process, gain recognition from a male significant other, assuage her guilt, and reduce her shame). But, as is often the case, these unconscious hopes were shattered. Similarly, Mr. Marks' unconscious search to find someone who would take responsibility for their relationship and who would allow him to maintain a safe level of interpersonal relatedness also turned to frustration and disappointment as Mrs. Marks began to make more demands for greater involvement.

As is often the case in seriously distressed marriages, there was a negative complementarity and dovetailing of personal themes and lifestyle solutions that served as a basis for negative, homeostatic themes in the couple's conjugal mythology. The couple's relationship appeared to have stabilized around two conjugal themes prior to Mrs. Marks' affair.

The affair served to stabilize the marriage for a considerable amount of time. It allowed Mr. Marks the interpersonal distance he needed and permitted him to avoid dealing with unresolved issues of loss, abandonment, death, and guilt. Mrs. Marks was able to get the attention and validation she so desperately craved. **However, as she became more deeply involved in the affair, her guilt was compounded, and she began to feel overwhelmed. Her self-esteem plummeted, and her feelings of worthlessness returned**. Something had to be done to break this negatively escalating cycle that was about to spin out of control. Her disclosure of her affair to Mr. Marks brought this downward spiral to a halt and the couple into therapy.

Treatment

Based upon the empirical assessments conducted with this couple, a number of salient clinical issues emerged:

- **Moderate, yet important, ideal spouse/perceived spouse discrepancies for both Mr. and Mrs. Marks**, which resulted in marital frustration and dissatisfaction
- **Major inequities perceived by both spouses in the conjugal exchange process leading to severe marital dissatisfaction and conflict**; these included: finances, religion, sexual relations, children, household responsibilities and marital roletask assignments, expressions of love and affection, recreation, friendships and marital communication
- Marital cohesion and adaptability conflicts
- Significant discrepancies between the spouses in intimacy needs and satisfactions
- Unresolved issues, for both Mr. and Mrs. Marks, with their families of origin, which negatively affected the functioning of the marital dyad

The clinical interviews with Mrs. Marks revealed that although she had ended her sexual relationship with her lover, she was still struggling with her emotional attachment to him. Furthermore, she was uncertain whether she wanted to continue in her relationship with Mr. Marks. Therefore, the couple was advised to consider a 3-month structured separation (Toomen, 1972) so that both spouses could consider whether they wanted to remain in the marriage and work cooperatively toward its improvement. During this period of time, individual and marital sessions were held. **When Mr. and Mrs. Marks were seen together, they were taught functional communication skills, conflict negotiation strategies and problem-solving techniques** (Bagarozzi & Anderson, 1989) **so that they could begin to tackle some of the concrete concerns and issues that led up to their current crisis and brought them in for therapy**. Mr. and Mrs Marks decided that a structured separation would be appropriate for them, and Mr. Marks began to make plans to rent an apartment for the 3-month period of their separation.

Summary of Individual Sessions During Structured Separation

MRS. MARKS:

During the beginning phase of their separation process, Mrs. Marks grappled with her unresolved feelings about her former lover and her uncertainties about her relationship with her husband and her future with him. One difficult dilemma involved the possibility that she really might be deeply in love with both her husband and her former lover for very different reasons. She loved Mr. Marks for his rational approach to life, his pragmatism, his intelligence, his honesty, and his integrity. Mr. Marks had always treated her as an equal. He respected her autonomy and had always supported her professional development. Her feelings for her lover, however, centered upon his emotional and psychological availability, his devotion to her, his sense of humor, and his intense sexual interest in her.

In her individual sessions, **Mrs. Marks began to explore the oedipal dynamic of her relationship with her former lover. He was a married man who was separated from his wife and 4-year-old daughter. On one hand, she saw herself as the triumphant daughter who takes father away from mother. On the other hand, she identified with the child who is abandoned by her father**. She recalled how upset she became during her childhood whenever her father left home for months at a time during his military career. These insights had profound effects upon Mrs. Marks, and she became aware of numerous unresolved issues between herself and her parents that required attention.

As treatment progressed, Mrs. Marks began to understand the transferential elements in her relationship with her former lover. She realized that she had never received the love, support, and recognition from her father that she craved, and that other men could never fill this void. These insights led to a period of depression. The realization that she could not recreate the past in order to correct past wrongs and resolve unmet infantile needs was extremely difficult for Mrs. Marks to handle.

At this juncture, the focus of treatment became Mrs. Marks' rage and resentment against her father whom she perceived as abandoning her and neglecting her even when he was present. She also verbalized her deep resentment for men who only paid attention to women when they wanted sex. Processing these feelings allowed her to see that her husband was not like these men. She began to see Mr. Marks in a new light, and her appreciation of him became stronger than it had been in the past. She knew that Mr. Marks' interest in her was much more than sexual. Even though he had not been able to fulfill her needs for emotional and psychological intimacy, he loved her in his own way, and he loved her for herself. At this point in therapy, Mrs. Marks began to question the actual strength of her sexual needs. She wondered whether her sex drive was really as strong as she had indicated on the Intimacy Needs Survey. She wondered if she had been using sex to gain men's attention and to prevent them from abandoning her.

As these issues were examined, Mrs. Marks became aware of her ambivalent feelings about sex and herself as a sexually attractive person. Sex was pleasurable but it sometimes produced painful consequences. Her sexual attractiveness was a major source of her self-esteem, but it was also a source of intense shame. These insights, although difficult to face, allowed Mrs. Marks to look at her affair in a more objective and less romantic way: She saw that much of the time spent with her former lover took place in the bedroom. Furthermore, she admitted to herself that sex with him had not been very fulfilling. As a result of this work in her individual sessions, Mrs. Marks decided to sever all communication with her former lover and to devote her time and energy to strengthening her marriage and repairing her relationship with her husband. Any misgivings she had about this decision were put to rest when she informed her former lover that she had decided to recommit to her marriage.

Shortly after this experience with her former lover, Mrs. Marks' depression began to lift. Individual sessions focused on editing themes I and II from her personal mythology. She was helped to recognize and appreciate herself for her own personal (not necessarily sexual) qualities, professional accomplishments, and unique talents. Drawing attention to herself became less important, and she began to discourage sexual advances from men. As she did this, she noticed that her male colleagues began to compliment her for her business savvy and professional accomplishments. By not being seductive, she found that she was being noticed by others. This was a new experi-

ence for Mrs. Marks. The attention she was now garnering was appropriate, and she felt much more comfortable with herself. She began to cultivate friendships with men and women who admired her intellectual abilities and business skills.

MR. MARKS:

Individual work with Mr. Marks began with helping him learn how to experience, identify, label, and express his feelings. This was not an easy task for him, because, as mentioned previously, repression, denial, and intellectualization were his most common defenses.

As Mr. Marks became aware of his feelings, he found himself more able to discuss his true feelings about Mrs. Marks' affair with her during their weekly marital sessions. The disclosure of his anger, jealousy, and resentment was, at first, difficult for Mrs. Marks to hear; she became defensive and visibly upset when he expressed these negative feelings. On several occasions, she threatened to end their marriage when Mr. Marks expressed his anger. Her behavior was confusing to Mr. Marks, because she had often chided him for not expressing his feelings to her. Now that he was doing so, she was offended! Her behavior served to activate theme I from his personal mythology (i.e., the effects of intimacy are unpredictable). However, through individual sessions and couple sessions, Mrs. Marks was able to see that Mr. Marks was indeed becoming more emotionally and psychologically intimate with her for the first time in their relationship.

Next, Mr. Marks began to struggle with theme II from his personal mythology (i.e., fears of rejection, abandonment, and loss). It was during this phase of his individual work that Mr. Marks disclosed the information about his girlfriend's abortion. These sessions made it possible for him to begin to deal with his unresolved mourning and impacted grief.

Summary of Marital Sessions During Structured Separation

Based upon the assessment findings reviewed earlier and the treatment issues outlined above, **Mr. and Mrs. Marks were taught functional communication skills so that they could begin to tackle their disappointments and previously unverbalized expectations relating to their ideal spouse/perceived spouse discrepancies** (Bagarozzi & Anderson, 1989). **Not only does this training procedure teach couples how to communicate more effectively, it also facilitates empathy, role taking, and self-disclosure, thereby promoting a greater degree of intimacy**.

Once Mrs. Marks had made the decision to remain in her marriage and to focus on improving her relationship with Mr. Marks, the couple was taught the behavioral exchange/contingency contracting model of conflict negotiation developed by Bagarozzi and Anderson (1989). **Contracting for specific behavioral changes usually eases the transition to living together again as a couple once the structured separation is over, because expectations for one's spouse and the marriage have been clearly delineated and openly agreed upon by both members of the couple**.

Working Through Central Themes in the Couple's Conjugal Mythology

Theme I in Mr. and Mrs. Marks' conjugal mythology concerned interpersonal distance/closeness (intimacy) and validation (love, praise, attention, recognition, etc.) of the self/self-esteem that translated into a distancer/pursuer behavioral dynamic between the spouses.

Training in functional communication skills with its emphasis upon empathy, role taking, and open

disclosure of thoughts and feelings within a safe therapeutic context reduced Mr. Marks' tendency to distance while allowing him to become more self-disclosing and intimate with his wife. Through this process, Mrs. Marks began to feel more connected to her husband and, for the first time, was able to hear and appreciate his positive and supportive statements about her and her accomplishments. This gave her some sense of recognition and praise as well as conveying to her that she was loved by Mr. Marks.

As a result of her individual work, Mrs. Marks was able to see that some of the anger, frustration, and resentment she felt toward her husband was displaced (transferred) from her father. This understanding made it possible for Mrs. Marks to experience her husband in a more positive and less distorted way. She became less critical, more affectionate, and more even-tempered in her dealings with Mr. Marks. As a consequence of these changes, Mr. Marks began to view his wife as more predictable. The positive feelings about his wife's consistent treatment of him became the subject of Mr. Marks' individual sessions (at this time), and he began to discuss these feelings (and others) with Mrs. Marks in their marital sessions. Gradually, Mr. Marks' personal theme that "the consequences of intimacy are unpredictable" was modified to some degree. The revised theme is best described as "measured and cautious self-disclosure with people who have proven themselves to be consistent and predictable."

The more self-disclosing and emotionally available Mr. Marks became during the couple's sessions and in their meetings outside the therapist's office, the more intimacy Mrs. Marks began to experience in her interactions with her husband. She also began to feel less ignored and more appreciated by Mr. Marks, and her self-esteem improved. As her self-confidence grew, she no longer felt the need to act-out in ways that were designed to capture her husband's attention.

However, her "terrible secret" still caused Mrs. Marks a considerable amount of discomfort. Just prior to her affair, she had attempted to get Mr. Marks to assuage the gnawing guilt associated with her abortion, but her introduction of this information into their relationship created a disequilibrium in the couple's precariously balanced system. **By bringing up this topic for open discussion, Mrs. Marks violated her part of an unconscious marital contract** that was central to maintaining a smoothly functioning relationship between the spouses (Bagarozzi & Anderson, 1989; Sager, 1976). The spouses' collusive and mutually protective unconscious quid pro quo is described by the following remarks:

> *Mrs. Marks:* "I will not mention my abortion so that you will not have to deal with the pain of your unresolved mourning and grief about your brother's death and your feelings of guilt and responsibility. You will protect me by helping me avoid my feelings of shame (for my sexual promiscuity) and guilt (for my abortion) by not asking me about my past or current behavior."
>
> *Mr. Marks:* "I will not question you about your past or present behavior so as not to stir up any feelings of inadequacy or shame or guilt (sexual promiscuity and abortion), and you will protect me by avoiding any issues that might cause me to experience my own shame and guilt.

The open and frank discussion of this contract was brought about by the therapist's outlining what he believed to be the major clauses of this unconscious quid pro quo. This interpretation ushered in a very emotional discussion between the spouses who confirmed that a mutually protective contract probably did exist between them. Mr. Marks then disclosed his own secret about his former girlfriend's abortion and shared with his wife the shame and guilt he had been

avoiding for so many years. An emotional and tearful Mr. Marks then explained that as a result of this experience he felt unworthy to have a child of his own. To be sure, he then told Mrs. Marks that **when she disclosed that she had had an abortion, he was convinced that any child born to them would be stillborn, deformed, or abnormal. Mr. Marks also revealed that he had sometimes wondered if his brother's death was not some sort of divine punishment or retribution for his inaction—his failure to do anything about his girlfriend's abortion or his brother's drug addiction.**

Mr. Marks' revelations were received with empathy, sympathy, and understanding by Mrs. Marks. For her, these disclosures signified a removal of her husband's barriers to intimacy. His wife's nonjudgmental acceptance of Mr. Marks' disclosures enabled him to listen to Mrs. Marks' descriptions of her own pain, suffering, and guilt about her abortion and her affair. **This mutual sharing of pain and hurt was the prelude to the couple's working through of their unresolved mourning and impacted grief. As this process unfolded, it became evident to the couple that their unconscious agreement to protect each other from painful feelings and experiences was a major cause for the lack of intimacy in their marriage**. An important aspect of this couple's healing was their decision to join a church together. Shortly after they began to attend weekly church services, Mr. Marks moved back into their home. They then began to discuss the possibility of having children in the relatively near future.

Post-Treatment Evaluation

Therapy was concluded after 8 months. Pre-treatment/post-treatment scores for the Locke-Wallace Marital Adjustment Test show considerable increases for both spouses (e.g., Mr. Marks, 58 to 116; Mrs. Marks, 88 to 130). Discrepancy scores decreased from 21 to 8 for Mr. Marks and from 28 to 11 for Mrs. Marks. SIDCARB score changes for Mr. Marks were: 69-57 (factor I); 39-39 (factor II); and 38-56 (factor III). For Mrs. Marks they were: 77-62 (factor I); 39-42 (factor II); 55-65 (factor III). **These SIDCARB scores show that they spouses are more satisfied with the fairness of the exchange process and both desire fewer changes in their mate's behavior than at the outset of treatment. However, Mrs. Marks' dissatisfaction/change score (factor I) still exceeds one standard deviation above the mean, indicating that she would still like to see some additional changes. Mr. Marks' factor I post-treatment score reveals that he was significantly more satisfied with the exchange process at the end of treatment. His post treatment score of 57 falls within the satisfied range for this factor.**

Little change was recorded for the second factor (internal psychological barriers) for both spouses, but a considerable increase on factor III (external circumstantial barriers) emerged for each spouse. This sometimes results from a structured separation, especially when the spouses realize that they will be unable to maintain the same lifestyle and standard of living as divorced, single persons.

A comparison on FACES III perceived-ideal discrepancy scores for both spouses at post-treatment evaluation showed the following changes: for Mr. Marks, perceived= chaotically/separated to flexibly/connected; ideal=flexibly/connected to flexibly/connected. For Mrs. Marks, pre-treatment/post-treatment changes were: perceived= chaotically/separated to flexibly/connected; ideal=flexibly/connected to flexibly/enmeshed.

According to these findings, Mr. Marks appears to have achieved his ideal as a result of therapy. How-

ever, although Mrs. Marks seems to have achieved her ideal relationship with her husband by the end of treatment, her post-treatment ideal shows that she still desires further closeness.

As one would expect, Table 1 shows only slight changes in the overall intimacy need strengths for both Mr. and Mrs. Marks. However, receptivity satisfaction and reciprocity satisfaction percentages show substantial increases for all six component dimensions of intimacy identified as problemtic by Mrs. Marks. Similarly, the three dimensions of concern identified by Mr. Marks also show considerable positive changes at the end of treatment.

Finally, PAFS-Q scores for both spouses showed moderate changes at post-treatment evaluation. The scores are shown in Table 3.

Conclusion

The percentage of women who suffer from PTSD as a result of having had an abortion is unknown. Empirical research into this very important family issue is sorely needed. Hopefully, this lesson will help encourage all clinicians, not just marital and family therapists, to inquire about this very sensitive topic and to be on the alert for any symptoms that might suggest the presence of a delayed stress syndrome in their clients.

In my clinical experience, **the resolution of this condition usually does not require long-term treatment, but no systematic follow-up studies have been conducted**. However, empirical evaluation of the marital therapy model outlined in this lesson is currently under way in order to determine to what degree treatment gains are being maintained.

Table 3
PAFS-Q Subscales

	Mr. Marks *Pre-Post*	*Mrs. Marks* *Pre-Post*
1. Spousal Intimacy	Low-Medium	Low-Medium
2. Spousal Fusion	Low-Low	Low-Low
3. Intergenerational Intimacy	Low-Low	Low-Low
4. Intergenerational Fusion	Low-Low	Low-Low
5. Nuclear Family Triangulation	High-Medium	Low-Low
6. Intergenerational Triangulation	High-Medium	Low-Low
7. Intergenerational Intimidation	Low-Low	High-medium
8. Personal Authority	High-High	Low-Medium

REFERENCES

Anderson, S. A., & Bagarozzi, D. A. (1983). The use of family myths as an aid to strategic therapy. *Journal of Family Therapy, 5*, 145–154.

Anderson, S. A., & Bagarozzi, D. A. (1989). Family myths: An introduction. *Journal of Psychotherapy and the Family, 4*, 3–16.

Anderson, S. A., Bagarozzi, D. A., & Giddings, C. W. (1986). IMAGES: Preliminary scale construction. *The American Journal of Family Therapy, 14*, 357–363.

Anderson, S. A., & Sabatelli, R. M. (1990). Differentiating differentiation and individuation: Conceptual and operation challenges. *The American Journal of Family Therapy, 18*, 32–50.

Bagarozzi, D. A. (1983). Methodological developments in measuring social exchange perceptions in marital dyads (SIDCARB): A new tool for clinical intervention. In D.A. Bagarozzi, A.P. Jurich, & R.W. Jackson (Eds.), *New perspectives in marital and family therapy: Issues in theory, research, and practice*. New York: Human Sciences Press.

Bagarozzi, D.A. (1993). Post-traumatic stress disorders in women following abortion: Some considerations and implications for marital/couple therapy. *International Journal of Family and Marriage, 1*, 51–68.

Bagarozzi, D.A. (1989). Family diagnostic testing: A neglected area of expertise for the family psychologist. *The American Journal of Family Therapy, 17*, 261–274.

Bagarozzi, D.A. (1990). *Intimacy needs survey*. Unpublished instrument.

Bagarozzi, D.A., & Anderson, S.A. (1982). The evolution of family mythological systems: Considerations for meaning, clinical assessment, and treatment. *Journal of Psychoanalytic Anthropology, 5*, 71–90.

Bagarozzi, D.A., & Anderson, S.A. (1989). *Personal, marital and family myths: Theoretical formulations and clinical strategies*. New York: Norton.

Blank, A.S., Jr. (1982). Stresses of war: The example of Viet Nam. In L. Goldberger & S. Breznitz (Eds.), *Handbook of stress: Theoretical and clinical aspects* (pp. 631–643). New York: The Free Press.

Bray, J., Williamson, D., & Malone, P. (1984). Personal authority in the family system: Development of a questionnaire to measure personal authority in intergenerational family processes. *Journal of Marital and Family Therapy, 10*, 167–178.

Byng-Hall, J. (1973). Family myths used as defense in conjoint family therapy. *British Journal of Medical Psychology, 46*, 239–250.

Dicks, H. V. (1967). *Marital tensions: Clinical studies toward a psychological theory of interaction*. London: Routledge and K'egan Paul.

Ericson, P. M., & Rogers, L. E. (1973). New procedures for analyzing relational communication. *Family Process, 12*, 244–267.

Janda, L. H., & O'Grady, K. E. (1980). Development of a sex anxiety inventory. *Journal of Consulting and Clinical Psychology, 48*, 169–175.

L'Abate, L., & Bagarozzi, D. A. (1993). *Sourcebook of marriage and family evaluation*. New York: Brunner/Mazel.

Lewis, R. A., & Spanier, G. B. (1979). Theorizing about the quality and stability of marriage. In W. R. Burr, R. Hill, F. I. Nye, & I. L. Russ (Eds.), *Contemporary theories about the family, Vol. I*. London: Free Press.

Lidz, T., Cornelison, A. R., Fleck, S., & Terry D. (1957). Schism and skew in the families of schizophrenics. In N. Bell & E. Vogel (Eds.), *A modern introduction to the family* (pp. 595–607). New York: The Free Press.

Locke, H. J., & Wallace, K. M. (1959). Short marital adjustment and prediction tests: Their reliability and validity. *Marriage and Family Living, 21*, 251–255.

Masters, V., & Johnson, W. (1970). *Human sexual inadequacy*. New York: Bantam Books.

Mosher, D.L. (1965). Interaction of fear and guilt in inhibiting unacceptable behavior. *Journal of Consulting and Clinical Psychology, 29*, 161–167.

Olson, D.H., Portner, J., & Lavee, Y. (1985). *FACES III*. St. Paul: University of Minnesota, Family Social Sciences.

Sager, C.J. (1976). *Marriage contracts and couple therapy: Hidden forces in intimate relationships*. New York: Brunner/Mazel.

Satir, V. (1967). *Conjoint family therapy*. Palo Alto, CA: Science and Behavior Books.

Toomen, M.K. (1972). Structured separation with counseling: A therapeutic approach for couples in conflict. *Family Process, 11*, 299–310.

Wambolt, F.S., & Wolin, S.J. (1989). Reality and myth in family life. *Journal of Psychotherapy and the Family, 4*, 141–166.

Wynne, L.C., Rycoff, I.M., Day, J., & Hirsch, S.I. (1958). Pseudomutuality in the family relations of schizophrenics. *Psychiatry, 21*, 205–220.

Questions Based On This Lesson

5. All of the following symptoms are listed as indicative of PTSD as a result of abortion *except*:

   A. Nightmares of being trapped in a man-made disaster

   B. Sudden change of career

   C. Sadomasochistic interactions

   D. Flashbacks of the surgical procedure

6. Which of the following is designed to assess the internal and external barriers to terminating the marriage?

   A. SIDCARB

   B. Locke-Wallace Marital Adjustment Test

   C. FACES III

   D. Intimacy Needs Survey

7. The themes that constitute an individual's personal mythology:

   A. Are completely different from the cultural and religious myths of society

   B. Are difficult to change once they are firmly established

   C. Define the present situation but cannot guide future actions

   D. Can be conscious or unconscious

8. According to the author, the resolution of PTSD following abortion:

   A. Always requires use of hypnotic techniques

   B. Should always be followed by periodic visits to ensure that the symptoms do not recur

   C. Is achieved more effectively if the frequency of sessions slowly decreases over time.

   D. Usually does not require long-term treatment

DIRECTIONS IN MARRIAGE AND FAMILY THERAPY © 1994, The Hatherleigh Company, Ltd.
All rights reserved. Not to be reprinted without permission of the publisher.

Special Program Coordinators: Dennis A. Bagarozzi, PhD Frederic Flach, MD

Editorial Board of Consultants: James Alexander, PhD; Stephen Anderson, PhD; Judith I. Bagarozzi, MS; Insoo Kim Berg, MSSW; William J. Doherty, PhD; Craig Everett, PhD; Charles Figley, PhD; Alan S. Gurman, PhD; Harvey Joanning, PhD; Florence Kaslow, PhD; James F. Keller, PhD; Luciano L'Abate, PhD; Pieter le Roux, PhD; Howard Liddle, PhD; Mel Markowski, PhD; Fred P. Piercy, PhD; Lynda Dykes Talmadge, PhD

Managing Editor: Debra E. Cermele

Associate Editor: Steven L. Pessagno

Directions in Marriage and Family Therapy is a continuing education program published by The Hatherleigh Company, Ltd., 420 East 51 Street, New York NY 10022. For additional information, please call 800-367-2550 or 212-355-0882 (outside the US).

Directions in Marriage and Family Therapy

VOLUME 2 • LESSON 3

The Death of a Child: Implications for Marital and Family Therapy

Paula P. Bernstein, PhD, and Leslie A. Gavin, PhD

Dr. Bernstein is Associate Clinical Professor at the University of Colorado Health Sciences Center and Adjunct Associate Professor at the University of Denver [CO].

Dr. Gavin is Assistant Professor at the University of Colorado Health Sciences Center and the National Jewish Center for Immunology and Respiratory Medicine, Denver, CO.

Parts of this lesson are adapted from: Bernstein, P. P., Duncan, W., Gavin, L. A., Lindahl, K. M., & Ozonoff, S. (1989). Resistance to psychotherapy: The effects of the death on parents and siblings. Psychotherapy, 26, 227-232.

KEY POINTS

- The loss of a child impacts every member of the family. For the parents, the child represents a future investment; the child's death threatens their identity and can result in overwhelming guilt.

- Appetite loss, separation anxiety, and extreme reactions to minor illnesses have been reported in surviving siblings; the parents' availability is a key factor in the surviving children's adjustment to the loss.

- Strains on the marital relationship after the loss of a child often are inevitable, primarily because the loss leaves both partners so mentally fatigued that they do not have the energy to provide emotional support for each other. Difficulties may also surface because the partners either mourn with incompatible styles of grieving or experience nonsynchronized mood cycles, thereby resulting in estrangement, faulty communication, or aggravation of preexisting marital problems.

- The emotional trauma associated with a miscarriage can be exacerbated because parents' reactions to miscarriages often go unrecognized and untreated. Some women who miscarry report being told, "It's all for the best" or, "You can just try again in a few months." These women often feel guilty for being depressed and isolated because they do not believe that those around them understand their painful feelings.

- Resistance is common to all families who have experienced child loss. The therapist must identify the loss and recognize its importance in all therapeutic work with the family. During the initial evaluation with family members, therapists should inquire about any major losses with the family and how many pregnancies they have experienced.

- Therapists should work with the family's resistance instead of against it. Gentle, supportive statements may help to ventilate anger. It is also helpful to focus on family members' strengths and how they previously used those strengths in troublesome times. Finally, normalization of the family's experience through statements of validation are quite useful in addressing grief.

Introduction

Each year in the United States, **approximately 94,000 children, ranging from newborns to young adults, die unexpectedly** (See Bernstein, Duncan, Gavin, Lindahl, & Ozonoff, 1989; Richter, 1986). **The loss of a child impacts every member of the family.** Sometimes, the family system is altered so profoundly that the effects of the trauma can be observed through generations.

Some parents who suffer from difficulties following the death of a child **do not consciously connect them with the loss**, even when problems in the family drive them to seek help. Indeed, parents may strongly resist making such connections, assuring therapists they have "gotten over" the death of their child. **The therapist's reluctance to reopen such a terrible wound may cause him or her to collude with the parents' resistance to doing the necessary grief work.** As we will show in a series of case examples, these resistances can decisively undermine the therapeutic process. In many instances, work is interrupted despite the best efforts of the therapist to keep the family in treatment.

The therapist must become attuned to the many ways the loss of child impacts a family in order to understand the best way to engage the family in treatment. **Focusing the treatment for the family depends upon the therapist's ability to "hear" the communications about the impact of the loss hidden in the family's behaviors.**

The Impact of Child Loss

Child loss is thought to be one of the most traumatic events possible in human experience. The **resulting grief appears to be more severe than that associated with the loss of a parent, adult sibling, or spouse** (Kübler-Ross, 1983; Rando, 1985; Rosen & Cohen, 1981; Sanders, 1980).

THE PARENTS:

When a child dies, the unique dynamics of the parent-child relationship cause parents to feel they have lost not only a child, but also a part of themselves (Rando, 1985). The **child represents a source of future investment, hopes, and dreams that are suddenly destroyed** (Zimmerman, 1981). The pain of the loss is continually renewed as the future unfolds without the child.

When parents lose a child, they lose a major functional role that may threaten their sense of identity. Of course, the loss means their daily routines and caretaking roles change radically. More painful still, the loss **threatens their sense of being adequate parents**, having been unable to fulfill parental duties of protection and nurturance (Rubin, 1985). As a result, many parents experience a **tremendous amount of guilt**, which may be unrelated to any objective responsibility for the child's death (Miles & Demi, 1984).

Kübler-Ross (1983) argues that guilt is heightened for couples whose child dies suddenly. These parents do not have the benefit of time to prepare for the death. According to Kübler-Ross, **without this time for reflection, undoing of things regretted, and concentration of loving energy on the dying child, it may be even more difficult to work through feelings of guilt and shock.**

THE MARITAL RELATIONSHIP:

The loss of a child seems to threaten the marital relationship in a way other losses do not. To begin with, in many life crises, it is only one partner who is significantly in pain and in need of support. When a couple loses a child, **both partners may experience tremendous grief, leaving them little energy to provide emotional support for each other** (Schiff, 1977; Zimmerman, 1981).

Difficulties also may arise when both spouses are mourning but have incompatible styles of grieving. For example, **one parent may be overtly emotional, whereas the other is quietly depressed or withdrawn**. The one who displays overt grief may believe that the other was not as attached to the deceased and may displace anger about the death on the "less caring" partner. Conversely, the one who "cannot stop grieving" may feel weaker and less worthy for not recovering as quickly. Some couples may have similar styles of grieving, yet their **mood cycles (alternating from sorrow to hopefulness about the future) may occur at different rates**. This lack of synchrony **may cause estrangement, blocked communication, or aggravation of preexisting problems in the marital relationship** (Rando, 1985).

The impact of these and other stressors may be seen in the **high divorce rate among grieving couples** (Schiff, 1977). The fact that many couples are geographically isolated from their extended families may intensify the strain on the marital relationship. At the same time, **it is not uncommon for support networks to evaporate in the face of tragedy. Friends and even members of the extended family are often so uncomfortable with the loss that they avoid the couple.**

THE SURVIVING SIBLINGS:

The loss of a sister or brother has a major effect on the lives of surviving siblings. Cobb (1956) studied parents' perceptions of their child's functioning following the loss of a sibling and noted **appetite loss, fear of separation from parents, and extreme reactions to minor illnesses**.

The sibling bond includes a narcissistic investment in one's siblings. When a sibling dies, the child loses an important object at a formative period in his or her life. The complex, ambivalent feelings inherent in the sibling relationship can complicate the child's mourning. **The relationship between the surviving child and the deceased sibling must be slowly reworked during the mourning process.**

The quality of the surviving child's relationship with each parent before the death influences the child's reaction to the loss. **The parents' availability is a key factor in the child's adjustment.** The fact that the child simultaneously loses the sibling and the parents' availability appears to be particularly salient. In many cases, parents are never the same (Pollock, 1978).

The loss of a sibling often has an impact on the way parents treat the surviving children. Parents may idealize the lost child and then compare surviving children to the one they have enshrined. Such comparisons almost always leave the surviving children feeling inadequate and further compound feelings of guilt and anger that they may have over the sibling's death (Turkington, 1984). Parents may overprotect surviving children or cast them in the role of a "replacement child," compromising their ability to develop a true self (Winnicott, 1965).

The ways in which children understand and adjust to the loss of a sibling are **affected by their level of cognitive and emotional development**. For example, Rose (1986) suggests that **children younger than age 5 may react with detached curiosity rather than a strong sense of loss, whereas adolescents may react with great visible distress, experiencing confusion, anger, and disorientation.** The therapist must explore each surviving child's conception of death and how the cause of death is imagined by each child. **To understand the child's predicament, the therapist should be sensitive to the degree to which the parents have been available to the child and whether support has been provided by other family members.** Although painful marital problems may go untreated indefinitely, it may be the maladjustment of a surviving child that incites the family to seek treatment.

Loss of a Child During Pregnancy

Reactions to losing a child during pregnancy often go unrecognized and untreated (Leon, 1990; Pines, 1993) **because it is assumed that spontaneous abortion is not accompanied by the same distress as other child loss. Women report being told such things as, "It's all for the best" and, "You can just try again in a few months."** Couples receive little social and emotional support and **feel guilty for being depressed**.

The few studies that have been conducted in this area, mostly with women, have found that women experience a sense of loss and some limitation of daily functioning after miscarriage (Zaccardi, Abbott, & Koziol-McClain, 1993), with **elevated levels of anxiety and severe depression** (Lindberg, 1992; Neugebauer et al., 1992; Thapar & Thapar, 1992). They often carry a sense of guilt about the loss and **do not believe that people around them understand their feelings** (Bansen & Stevens, 1992). Women who experience significant physical pain and bleeding after the event may worry that their own life is in jeopardy. In addition, little attention is paid to the heightened anxiety these women may feel during a subsequent pregnancy.

Persons at higher risk for psychiatric symptoms after miscarriage appear to be those with a past psychiatric history, poor social support, and previous history of miscarriage (Iles, 1989). As Pines (1993) pointed out, much of the mother-to-be's reaction to the loss **may depend on the conscious and unconscious meanings she has attached to the pregnancy and the subsequent loss**. For example, an ambivalent woman may experience miscarriage differently from one who is highly invested in parenthood. Parents who are trying to have their first child may experience miscarriage differently from those who already have children. Again, it is important to consider both the internal psychological and external social context in which the loss occurs.

Current Family Difficulties and Their Relation to the Trauma of Child Loss

We will now use case examples to discuss the various familial complications associated with child loss. The first three cases illustrate the types of problems that can develop in a family after a child dies. The fourth case illustrates how the effects of miscarriage can reverberate in the experience of subsequent children. The first three families were seen at a child psychological clinic (Bernstein et al., 1989, and the fourth child was being treated at a tertiary-care hospital for asthmatic children. **In all four cases, unresolved grief was continuing to operate as a pathogenic agent, leading to a host of diverse problems.** The parents had erected massive defenses against reopening the pain of their loss. In some cases, they brought the surviving child for treatment only on the condition that the subject of the dead child be avoided.

CASE #1:

Tommy was born 1 year after the cancer death of a 4-year-old sibling. He was referred to the clinic at age 9 because of **behavioral and emotional problems at school**, although **his parents reported no problems at home**. From the beginning of treatment, it was clear that **Tommy's parents were not interested in addressing the death of their other child**. In fact, therapy had been attempted previously and terminated twice when therapists had tried to associate the family's chronic problems with the death of their child. Tommy was strikingly immature, functioning at the level of a 4- or 5-year-old child, with **difficulty in regulating affect and impulses**. For several years, he had been placed in a special classroom for aggressive children.

Upon entering treatment, **Tommy quickly formed a dependent "wooing" transference with his female therapist**, wanting to sit on her lap and bring her gifts. Progress seemed slow, and the therapist felt frustrated. As we discussed this case, it became obvious that **Tommy was filling the role of a replacement child for his deceased brother** (Krell & Rablin, 1979; Pollock, 1978). It was as though he were destined, unconsciously, never to grow older than the child who was lost and never to separate or individuate. **His parents failed to set age-appropriate limits for him.** Rather, he was allowed to share his mother's bed when his father was working the night shift and was encouraged to sit on her lap. Such snuggling, which was overstimulating and disorganizing for Tommy, was regarded as perfectly normal by his parents. They hesitated to assert parental demands, unable to bear his anger, which implied the threat of separation and loss. As for Tommy, **he was enmeshed with his mother and claimed he would never leave her**.

Both parents were initially reluctant to change their relationships with Tommy. Eventually, **treatment centered on the establishment of more appropriate boundaries between Tommy and his mother, and his parents focused on the quality of their marital relationship**. The therapist realized that unless Tommy's parents could gain insight into the impact of the loss of the child Tommy had replaced, gains were likely to be quite unstable.

CASE #2:

Mr. and Mrs. B contacted the clinic under pressure from the school to obtain an evaluation of their 6-year-old son, Peter. **Teachers had become alarmed when they learned that Peter had tied a cord around his neck and jumped off a stairway.** School officials, social service workers, and an evaluator at a local hospital were concerned about this suicidal gesture and insisted Peter obtain treatment. His parents, however, wanted another opinion.

Peter presented as a **sad child with low self-esteem** who was **desperately seeking closeness and support from the adults in his life**. He was on odd-looking child who was suffering from **visual, motor, and auditory impairment. A second son, Bobby, had died of a congenital heart defect when Peter was 2 years old.** Mr. and Mrs. B's failure to deal with Bobby's death was interfering with their ability to be sensitive to their surviving son's needs. They were often emotionally unavailable to him. Eventually, this neglect pushed Peter to resort to extreme measures. He used the most powerful tool he knew to show his parents how miserable he felt and to call attention to what could not be discussed. **With his suicide attempt, he tried to confront them by essentially saying, "If I die, will you love me, too?"**

When the therapist tried to discuss Bobby's death, Mr. and Mrs. B reacted in a mildly hostile manner, complaining that the significance of that event was being exaggerated. They minimized their sadness and expressed a desire to "not live in the past." They believed the death had neither changed their behavior nor contributed to Peter's problems. **They refused to acknowledge Peter's depression and the frightening implication that he might be taken from them by death as well.** They became progressively more resistant to treatment, repeatedly canceling sessions and finally refusing to allow Peter to be seen at all. They insisted that their very troubled son was "just a normal kid" (i.e., not "defective" like the child they lost) and not in need of treatment.

CASE #3:

Ricky (age 6) and his family initially came to the clinic to address the problem of Ricky's noncompliance. Ricky's parents soon disclosed **significant marital difficulties**, having separated five times since they were married. **It was only Ricky, however, who shared that he had had a brother, John, who had died shortly after birth,**

when Ricky was 3 years old. When asked to draw his family, Ricky included John, depicting himself and his brother sleeping upstairs. Clearly, in Ricky's inner representational world, **John continued to be an important member of the family** who lived like a ghost in the house.

Ricky's parents had difficulty in talking about their loss or seeing its relevance to their current problems. Ricky's father was struggling with substance abuse, and his mother was suffering from depression. They coped differently with the loss, which caused some tension between them. **Ricky's father was anxious to "move on with life" and leave the loss behind, whereas his wife thought about the death often and felt as though she would always mourn John.**

In treatment, Ricky was constricted and his affect flat. He had **trouble engaging in playful behavior**. He was **angry and confused, struggling in a world in which perfect behavior was expected**. During the course of therapy, both Ricky and his parents wondered whether his problems might be caused by "not having a little brother to play with." After 8 months, shortly before the anniversary of John's death, the family ended treatment, making it impossible for the therapist to help them deal with the grief that would surely have been reawakened by the combined thrust of the anniversary reaction (Pollock, 1971) and the therapeutic process.

CASE #4:

Mary, a 34-year-old woman from a small southern city, brought her **3-year-old daughter, Jennifer**, to a tertiary referral hospital in a northern city to be evaluated for **allergic reactions and respiratory difficulties**. **Jennifer's symptoms reportedly occurred when she was exposed to the outdoor environment. These reactions became particularly problematic when Jennifer went to visit her father, Mary's ex-husband.**

Mary's divorce from her husband was deeply troubling to her, because her religion opposed divorce. Mary resented her husband for being unsupportive and, at times, psychologically abusive toward her during the marriage. Estrangement in the relationship had occurred several years earlier when she had two consecutive miscarriages due to endometriosis. She suffered deep emotional reactions to both losses, to which her husband was completely unresponsive. When she had become tearful 2 weeks after the second miscarriage, her husband had told her "to quit crying and get on with her life."

When Mary and her daughter were seen in the hospital, **Mary presented as an angry, stern woman who was enmeshed with her daughter**. Each day, they wore coordinated outfits, and Mary never left her daughter's side. **She would use the word "we" when describing her daughter's symptoms and explained that she knew exactly what Jennifer was experiencing because she suffered from the same allergic reactions.** She described the lengths she would go to at home to keep her child protected from the environment, which included having her wear a particle mask when going outside and confining her to an elaborate indoor play area. This consisted of an indoor "beach," complete with swings, slide, water, sand, and sunlamp. Mary stated that she resented it when people accused her of keeping her daughter in a "bubble," because she had everything she needed to live at home.

Despite extensive medical evaluation and environmental challenges, **Jennifer displayed no allergic reactions in the hospital**. She did, however, report numerous somatic complaints, which her mother would interpret as severe symptomatology. It was apparent to the consulting team that Jennifer was being kept forever safe in a warm, all-sufficient shelter that remarkably resembled a womb. **The therapist wondered with Mary whether her fears**

for Jennifer might be related to having lost two babies. Mary acknowledged that she grieved the loss of her babies every day and insisted that Jennifer was a delicate child who could die if proper attention was not paid to her allergic symptoms. Therapeutic work with Mary focused on her overinvolvement with her daughter, her tendency to see her daughter as vulnerable, and her extreme distress at seeing her daughter experience any physical discomfort. The therapist's task was to help Mary find ways to explore how unresolved feelings about the miscarriages might be affecting her relationship with her surviving child.

Resistance to Treatment

The problems that finally brought these families into therapy were varied and difficult to treat. It was only in reviewing the lack of progress in the first three cases that we discovered, to our surprise, that each family had experienced the death of a child. Eventually, we realized this factor was central to the obstacles encountered in treatment. **In each case, the grief over the lost child had not been worked through.** The therapists had accepted this defense, not recognizing it as a critical resistance. When first presenting these cases, some therapists had forgotten the exact circumstances of the child's death, indicative of the degree to which they had unknowingly colluded with the parents' defenses against the terrible pain of remembering. Treatment was being focused on the children's presentation of problems and was going nowhere. Treatment planning in the fourth case benefited from the experience gained as a result of the first study.

The parents were remarkably similar in their use of defensive denial, even using similar phrases in their refusal to acknowledge that the death might be contributing to current problems. For example, nearly every family expressed the desire to "move on" and "not live in the past." **Denial kept them from perceiving problems in their surviving children.** Peter's parents could not recognize his depression, even in the face of his suicidal gesture. Ricky's parents also pulled him out of treatment despite his obvious emotional pain. Tommy's parents cast him in the role of replacement child, oblivious to his real age and developmental needs; they stayed in treatment, but their rigid defenses effectively prevented an entire dimension of the family's problems from being addressed. In the case of Mary, her difficulty in resolving her miscarriages led her to overprotect her daughter to the point of keeping her in a womblike environment, turning her into an invalid and severely inhibiting her social and emotional growth.

We found that trying to convince the parents of the connection between current problems and the earlier loss only intensified resistance, turning a hoped-for alliance into an adversarial standoff. Conducting the treatment on the parents' terms led just as surely to a therapeutic stalemate. What can a therapist do in such a situation?

The fundamental first step in working with families who have experienced child loss is two pronged: **identify the loss and recognize its primary importance in any therapeutic work that will be completed with the family**. This requires **asking all family members at the time of the initial evaluation whether they have had major losses within their family, and how many pregnancies they have experienced**.

Therapists must be aware that families are likely to have major resistance to addressing questions related to their loss, even though it may be evident that issues of unresolved loss continue to be active in their lives. **The best avenue for understanding a family's need to defend against pain may be the therapist's awareness of his or her own inner trepidation about reopening**

the wound and sharing the anguish of their tragedy. If the therapist colludes with the family's position that the loss is irrelevant to the present, it will cause the therapy to stall. What is necessary is **a therapeutic stance balanced between ignoring the loss and continually bombarding the family with how issues of loss are being played out**.

It is important for the therapist to work with a family's resistance instead of against it, finding ways to explore it from within their own framework. **Gentle, supportive statements such as, "It must be very annoying when school authorities keep mentioning the death" may help parents ventilate their anger.** Gradually, parents may begin to feel safe enough to let their own concerns surface, almost in spite of themselves, saying something like, "Teachers and therapists ought to realize how sad it makes us feel!" or, "How unfair it is to question our ability to be good parents just because of the tragedy we've been through!" Peter's therapist could have commented on how the authorities seemed incredibly insensitive to the anxiety any parent who has lost a child might feel when outsiders suggest something might be wrong with a child who, thank heavens, is "normal."

It is also helpful to focus with family members on their strengths and on how they previously used those strengths in times of trouble. Questions such as, "How did you move on after such a terrible event?" open the subject while supporting the positive coping strategies of the family and do not criticize or "pathologize."

Normalization of the family's experience is important in helping them address their lingering grief. Comments like, "Many people don't recognize how devastating miscarriage can be" validate the grieving parents' experience. As the therapeutic alliance strengthens, the therapist may move further using the same approach; e.g., "Every parent who has lost a child has a heightened awareness of the fragility of life. This sometimes makes it difficult for them to allow their other children to take risks. What has been your experience?"

Some families refuse outright to discuss the death, because family members are afraid of triggering an emotional reaction that will disturb the family's equilibrium, which has been carefully maintained by tiptoeing around any mention of the subject. This is very difficult to address in therapy without losing the trust of the family. It is important to recognize the desire to protect and label it supportively as arising from their loving concern for each other. **It is common for one member, perhaps the father, to insist that discussion can only stir up painful memories. He wants his wife (and/or the children) protected from such pain. It may be helpful to ask the family member (most often the mother) whether she needs protection. We have found that the protected spouse often will discuss the loss openly.**

Once the family has begun to feel safe and understood within the therapeutic setting, the same loving concern may be mobilized on behalf of maximizing the developmental potential of the surviving children. The family may be willing to experience the pain of talking "once more" just to ensure the children are not adversely affected—now or in the future—by a traumatic event over which no one in the family had any control. **At this point, the therapist may be able to explore with parents and children the ways in which the aftereffects of the tragic experience continue to affect the family in subtle ways.**

In the case of prenatal loss, lack of attention to possible psychiatric symptoms immediately after miscarriage may lead to later difficulties for the mother, the marital relationship, and the family. Although it is important not to create problems where none exist, families should be offered the opportunity to address their grief and to **have feelings of sadness and fear normalized**.

Families may benefit from help in acknowledging the significance of the loss, support in obtaining medical information about the reasons for the loss, and working with the therapist on ways to mourn, including, for example, a memorial service for the lost child-to-be (Stirtzinger & Robinson, 1989).

Measuring Therapeutic Success

In these situations, therapeutic success may be **difficult to gauge**. It is commonly thought that **grief should last for 1 year and that any continued symptomatology past that point is pathologic. Professionals who work with victims of child loss recognize that families may never stop grieving**. Thus, **success with these families does not mean they will never feel sad or go through active grieving periods as the future unfolds without the child. Instead, signs of therapeutic success appear to be subtle changes in the family's way of coping with the grief.** Helping a family develop ways of talking about the lost member is critically important. For siblings, therapeutic success may hinge upon **providing a safe place to ask questions** they have never felt permitted to ask due to the perceived taboos in the family. **It may help to hold sessions in which family members "say goodbye" to the lost child in a way not possible before. Agreeing upon appropriate memorial rituals, such as visiting the grave on milestone occasions, can also help.**

Signs of successful therapeutic work include an acceptance that the grief will always be there to some degree, a forthright attitude toward issues related to death within the family, and the ability of family members to support each other without criticizing or isolating each other emotionally.

Conclusion

Families who have experienced the death of a child are especially in need of therapy and, at the same time, can be especially difficult to diagnose and treat. **The symptom picture can be confusing until its underlying dynamics are understood. Wary parents, consciously or unconsciously, perceive therapy as a Pandora's box.** The extraordinary pain involved in examining what is happening in the family and reopening the unresolved grief can cause parents to avoid seeking treatment or to abandon it prematurely. Failure to address the death often results in the lingering presence of a "ghost from the past" who works mischief in many ways. **The goal of family treatment is to turn the ghost of the lost child into a memory, freeing energies of parents and siblings for loving relationships, further development, and creative living.**

References

Bansen, S. S., & Stevens, H. A. (1992). Women's experiences of miscarriage in early pregnancy. *Journal of Nurse-Midwifery, 37*, 84–90.

Bernstein, P. P., Duncan, S. W., Gavin, L. A., Lindahl, K. M., & Ozonoff, S. (1989). Resistance to psychotherapy: The effects of the death on parents and siblings. *Psychotherapy, 26*, 227–232.

Cobb, B. (1956). Psychological impact of long illness and death of a child on the family circle. *Journal of Pediatrics, 49*, 746–751.

Iles, S. (1989). The loss of early pregnancy. *Baillieres Clinical Obstetrics and Gynaecology, 3*, 769–790.

Knapp, R. J. (1986). *Beyond endurance: When a child dies*. New York: Schocken Books.

Krell, R., & Rabkin, L. (1979). The effects of sibling death on the surviving child: A family perspective. *Family Process, 18*, 471–477.

Kübler-Ross, E. (1983). *On children and death*. New York: Macmillan.

Leon, I. G. (1990). *When a baby dies: Psychotherapy for pregnancy and newborn loss*. New Haven, CT: Yale University Press.

Lindberg, C. E. (1992). The grief response to mid-trimester fetal loss. *Journal of Perinatology, 12*, 158–163.

Miles, M. S., & Demi, A. S. (1984). Toward the development of a theory of bereavement guilt: Sources of guilt in bereaved parents. *Omega, 14*, 229–319.

Neugebauer, R., Kline, J., O'Connor, P., Shrout, P., Johnson, J., Skodol, A., Wicks, J., & Susser, M. (1992). Determinants of depressive symptoms in the early weeks after miscarriage. *American Journal of Public Health, 82*, 1332–1339.

Pines, D. (1993). Book review: I. G. Leon. When a baby dies: Psychotherapy for pregnancy and newborn loss. *Psychoanalytic Quarterly, 62*, 467–469.

Pollock, G. H. (1971). On time and anniversaries. In M. Kanzer (Ed.), *The unconscious today*. New York: International Universities Press.

Pollock, G. H. (1986). Childhood sibling loss: A family tragedy. *The Annual of Psychoanalysis, 14*, 5–34.

Rando, T. A. (1985). Bereaved parents: Particular difficulties, unique factors, and treatment issues. *Social Work, 30*, 19–23.

Richter, E. (1986). *Losing someone you love: When a brother or sister dies*. New York: Putnam.

Rosen, H. (1986). When a sibling dies. *International Journal of Family Psychiatry, 7*, 389–396.

Rosen, H., & Cohen, H. L. (1981). Children's reactions to sibling loss. *Clinical Social Work Journal, 9*, 211–219.

Rubin, S. S. (1985). Maternal attachment and child death: On adjustment, relationship, and resolution. *Omega, 15*, 347–352.

Sanders, C. (1980). A comparison of adult bereavement in the death of a spouse, child, and parent. *Omega, 10*, 303–322.

Schiff, H. S. (1977). *The bereaved parent*. New York: Penguin Books.

Stirtzinger, R., & Robinson, G. E. (1989). The psychological effects of spontaneous abortion. *Canadian Medical Association Journal, 140*, 799–801.

Thapar, A. K., & Thapar, A. (1992). Psychological sequelae of miscarriage: A controlled study using the general health questionnaire and the hospital anxiety and depression scale. *British Journal of General Practice, 42*, 94–96.

Turkington, C. (1984). Support urged for children in mourning. *APA Monitor, 15*, 16–17.

Winnicott, D. W. (1965). Ego distortion in terms of true and false self. In *The maturational processes and the facilitating environment*. New York: International Universities Press.

Zaccardi, R., Abbot, J., & Koziol-McLain, J. (1993). Loss and grief reactions after spontaneous miscarriage in the emergency department. *Annals of Emergency Medicine, 22*, 799–804.

Zimmerman, J. P. (1981). The bereaved parent. In O. S. Margolis, H. C. Raether, A. H. Kutscher, J. B. Powers, I. B. Seeland, R. DeBellis, & J. Cherico (Eds.), *Acute grief: Counseling the bereaved*. New York: Columbia University Press.

SUGGESTED READING

Balk, D. (1983). Adolescents' grief reactions and self-concept perceptions following sibling death: A study of 33 teenagers. *Journal of Youth and Adolescence, 12*, 137–161.

Colonna, A. B., & Newman, L. M. (1983). The psychoanalytic literature on siblings. In A. J. Solnit, R. S. Eissler, & P. B. Neubauer (Eds.), *The psychoanalytic study of the child* (Vol. 38). New Haven, CT: Yale University Press.

Edelstein, L. (1984). *Maternal bereavement*. New York: Praeger Books.

Knapp, R. J. (1986). *Beyond endurance: When a child dies*. New York: Schocken Books.

Neubauer, P. B. (1983). The importance of the sibling experience. In A. J. Solnit, R. S. Eissler, & P. B. Neubauer (Eds.), *The Psychoanalytic study of the child* (Vol. 38). New Haven, CT: Yale University Press.

Pollock, G. H. (1986). On siblings, childhood loss, and creativity. *The Annual of Psychoanalysis, 6*, 443–481.

Rosen, H. (1985). Prohibitions against mourning in childhood sibling loss. *Omega, 15*, 307–316.

Rosen, H. (1986). *Unspoken grief: Coping with childhood sibling loss*. New York: D. C. Heath.

Questions Based On This Lesson

9. With regard to a surviving sibling's reaction to child loss in his or her family:

   A. The parents' availability is not a key factor in the sibling's adjustment

   B. Those younger than age 5 tend to react with a strong sense of loss rather than with detached curiosity

   C. It is inappropriate for the therapist to explore the surviving sibling's conception of death and how the cause of death is imagined by the child

   D. The reaction is affected by his or her level of cognitive and emotional development

10. Which of the following statements is false?

   A. Because it is assumed that spontaneous abortion is accompanied by the same distress as other child loss, reactions to losing a child during pregnancy rarely go unrecognized or untreated.

   B. Research has shown that women who experience a miscarriage react with a sense of loss, elevated levels of anxiety, and severe depression.

   C. Persons at higher risk for psychiatric symptoms after miscarriage appear to be those with a past psychiatric history, poor social support, and previous history of miscarriage.

   D. An ambivalent woman may experience miscarriage differently from one who is highly invested in parenthood.

11. In the case of Tommy:

   A. Treatment centered on the establishment of more appropriate boundaries between Tommy and his mother

   B. Tommy tied a cord around his neck and jumped off a stairway at school in an effort to communicate the following to his parents: "If I die, will you love me, too?"

   C. His parents sought therapy to deal with Tommy's noncompliance.

   D. His mother, a hypochondriac who was convinced she had life-threatening allergies, inflicted tremendous psychological harm on Tommy by nearly overdosing on diphenhydramine (Benadryl)

12. According to the authors, which of the following statements is true?

   A. In the initial interview, it is inappropriate for therapists to inquire whether the family members have had major losses in their family.

   B. Statements like, "It must be very annoying when school authorities keep mentioning the death" do not help parents ventilate their anger, because they perceive such statements as patronizing.

   C. Some family members refuse outright to discuss the death of a child out of fear for triggering an emotional reaction that will upset the family's equilibrium.

   D. Measuring therapeutic success with families that have experienced child loss is relatively easy.

Directions in Marriage and Family Therapy © 1994, The Hatherleigh Company, Ltd.
All rights reserved. Not to be reprinted without permission of the publisher.

Special Program Coordinators: Dennis A. Bagarozzi, PhD Frederic Flach, MD

Editorial Board of Consultants: James Alexander, PhD; Stephen Anderson, PhD; Judith I. Bagarozzi, MS; Insoo Kim Berg, MSSW; William J. Doherty, PhD; Craig Everett, PhD; Charles Figley, PhD; Alan S. Gurman, PhD; Harvey Joanning, PhD; Florence Kaslow, PhD; James F. Keller, PhD; Luciano L'Abate, PhD; Pieter le Roux, PhD; Howard Liddle, PhD; Mel Markowski, PhD; Fred P. Piercy, PhD; Lynda Dykes Talmadge, PhD

Managing Editor: Debra E. Cermele

Associate Editor: Steven L. Pessagno

Directions in Marriage and Family Therapy is a continuing education program published by The Hatherleigh Company, Ltd., 420 East 51 Street, New York NY 10022. For additional information, please call 800-367-2550 or 212-355-0882 (outside the US).

Directions in Marriage and Family Therapy

VOLUME 2 • LESSON 4

Feminist and Traditional Family Therapies

Barbara L. Brown, PhD, and Margot W. Harter, PhD

Both Drs. Brown and Harter are clinical psychologists in private practice in Fayetteville, AR.

VOL. 2, NO. 4

1994

Key Points

- The family therapy approach emphasizes that the family can be treated as a unit—more significant than the sum of its individuals—and is characterized by developmental patterns of interactions that color the functioning of all its members.

- In the 1980s, previously espoused feminist ideas were applied to family therapy. Family dysfunction was thus viewed as being influenced by social and political attitudes that tend to subordinate women. Feminist family therapy is primarily mindful of the impact of gender differences on the functioning of the family.

- Part of feminist family therapy technique involves questioning socially accepted feminine roles that relate to the family, such as whether women should devote themselves and their energy exclusively to the current family system.

- Feminist family therapy opposes the trend in traditional family therapy that places an overwhelming responsibility for family dysfunction on the mother.

- Traditional family therapy views causality in the family as generally circular, self-reinforcing, and homeostatic, whereas feminist family therapy views causality as at least partly linear. For example, in a case of spouse abuse, circular reasoning would imply that all members are somehow responsible for the abuse. Feminist therapy rejects this implicit notion of "blaming the victim" that can, in fact, remove responsibility from the abuser.

- Feminist family therapy dictates that the political aspects of class and ethnicity significantly affect family dysfunction.

- Both approaches to family therapy maintain that the social context in which people exist is a prime determinant of behavior, reject the medical model as an explanation of individual differences, and emphasize moving away from blaming the victim.

Therapists who work with families know that such work can be a formidable task. Far from simply being a collection of individuals, the family unit has a life of its own. The traditional approach to individual therapy, which deals with intrapsychic structures and conflicts, does not appear to work well with families. It is clear that in a family, forces beyond the intrapsychic are at work: **each member impacts on every other member in such a manner as to render the family group more than the sum of its parts.**

Historical Perspectives

In the late 1940s and the 1950s, a growing number of therapists began a dialogue concerning the conception of the family and how it might be treated effectively. In the late 1940s, Salvador Minuchin, Murray Bowen, Nathan Ackerman, and Lyman Wynne joined with Gregory Bateson, Jay Haley, Don Jackson, and John Weakland to form a recognized discipline on the treatment of the family. Both groups began their new approach by studying the dysfunctional interactions and communications of mother/child dyads. The family model grew from these research results, and it was in the 1950s that the family systems approach emerged.

After initial focus on what was defined as the pathologic mother/child interactions, these pioneers agreed on the essential concepts of the family therapy approach. Although various leaders of the field proposed their own theories, the concept of "the system" united them. Despite the differences, **the common thread running through all the theories was the belief that the family could best be viewed as a unit characterized by developmental patterns of interactions that color the functioning of all its members. The unit of interest in the theory and practice of this therapy was the family system, functioning in the present. Family dysfunction was thought to be the result of rigid roles, rules, power differentials, and structures.** This represented a clear divergence from the traditional psychoanalytic focus on the individual, whose present reality was understood in the diffuse light of past experience. **Another significant difference between family therapy theories and the psychoanalytic approach was the view that causality was circular and not linear.** This led to the belief that intervention at one point in the system would instigate change throughout the family.

The feminine voice was absent in the early years of the development of family therapy. The first woman to play a leadership role was Virginia Satir in the late 1950s. The reason for the lack of female participation in the development of the field of family therapy is perhaps best explained by the fact that the early pioneers were male psychiatrists who already possessed sufficient recognition and institutional backing to support their radical ventures in working with families. At that time, few women in research settings were in the position to take a lead in the departure from traditional theory.

Satir's experience in a leadership position ironically mimicked the common experience of women in families. When she joined her male colleagues in exploring the boundaries of family therapy theory and technique, she was accepted and encouraged; however, as she began to develop her own perspectives and orientations toward the "feeling" dimensions of systemic thinking, she was ostracized by her male colleagues, who were more focused on problem solving and action-oriented change. This professional dispute led to a break in professional collaboration, at which time Satir went her own way, no longer to be affiliated with the field of the family systems approach to therapy.

In the 1970s, the feminine voice was augmented by the diverse contributions of Cloe Mandanes, Mara Selvini-Palazzoli, Monica McGoldrick, Lynn Hoffman, Peggy Papp, Olga Silverstein, and others. With the theoretic contributions made by Silverstein and Papp, it became clear that women had important and unique qualities to add to the field of family therapy. **The fact that many of these women emerged as leaders in a field in which they dealt personally with the effects of gender role restrictions makes their work particularly relevant to the dialogue between feminists and proponents of the family systems approach. During the 1980s, several of these women attempted to address the issues of gender in the practice of family therapy** (Simon, 1984).

Common Practices of Family Therapy

The practice of family therapy today comprises many different approaches. However, **common practices are still readily identifiable: a focus on the present, brief treatment time, a belief in nonlinear causality, and a focus on family interactions rather than the history of a single member.** Consistent with the awareness of the differing roles within the family system is the recognition that roles change as individuals develop. It is suggested that **a healthy, functioning family reorganizes itself to accommodate the changing developmental needs of its various members. Dysfunction often is highlighted when a developmental transition becomes mired by role rigidity or other negative patterns, such as triangulation, disengagement, or enmeshment.**

Feminist Family Therapy

In this lesson, the term "family therapy" implies a structural/strategic approach considered to be the traditional family therapy model. **Feminist family therapy is meant to imply a form of family therapy particularly mindful of the impact of gender differences on the functioning of the family.**

With the advent of the modern feminist movement, concerns about therapy were expressed by clients and therapists who resonated with the feminist philosophy and perception of relationships. The power differences between therapist and client were described as potentially problematic. **Feminist concerns about unequal power relationships in the therapeutic milieu grew from the political and sociological analysis of power as it was "enjoyed" by men, compared with women, in our society.**

Hare-Mustin (1978) wrote that feminist therapy grew out of the theory and philosophy of consciousness raising. She pointed out that central to this theory is the recognition that "the traditional intrapsychic model of human behavior fails to recognize the importance of the social context as a determiner of behavior" and "the sex roles and statuses prescribed by society for females and males disadvantage women." She went on to say that "feminism sees as the ideal for the individual the ability to respond to changing situations with whatever behavior seems appropriate, regardless of the stereotyped expectations for either sex" and that "feminist therapy has encouraged women not only to become aware of the oppressiveness of traditional roles but also to gain experiences that enhance their self-esteem as they try new behaviors as part of gaining self-definition."

Wheeler (1985) stated that portions of the feminist critique that impact upon family therapy are radical and may be somewhat frightening to more traditional therapists. According to Wheeler, **to be feminist is to:**

- **Assert the value of women's experiences in a society structured to devalue women**
- **Challenge the inequities in power and privilege that exist between men and women**

- **Acknowledge roles and values, subjectivity, personal experience, and politics in clinical work, teaching, and research**
- **Question whether the institution of the family as currently structured is a viable place for women to commit so much of their time and energy**
- **Reexamine family therapy and one's commitment to it**
- **Open oneself up to continuous self-examination regarding one's own honesty, responsibility, and integrity**

A feminist approach to family therapy is not antithetical to a family systems approach. In fact, it **incorporates many aspects of it**; e.g., the emphasis on social context as a prime determinant of behavior; the use of reframing and relabeling to shift the conceptual or emotional perspective of a situation; modeling; and an emphasis on action and behavioral change (Caust, Libow, & Raskin, 1981). **The feminist approach to family therapy also is committed to facilitating equality in personal power between men and women and in supporting clients' rights to design their lives outside the realm of culturally prescribed sex roles** (Rice & Rice, 1977).

As emphasized by Wheeler, Avis, Miller, and Chaney (1985), a feminist approach to family therapy is committed to recognizing the unique problem women face as a result of their socialization, and it emphasizes changes that benefit women within the family system. **Feminist therapy calls for a more political, institutional, and gender-sensitive viewpoint, which challenges familial and societal barriers so that women can participate equally with men.** Rowbotham (1973) noted that feminist family therapy must support and validate women's work both within and outside the family. The feminist perspective views men as victims of a sexist culture, with its rather rigid patterns of socialization—even though men still hold greater positions of power and privilege. Wheeler (1985) pointed out that "the overall goal of integrating feminist ideas into family therapy is to change the institution of the family so that those women and men who choose to participate in family life can do so cooperatively as equal and intimate partners. This formidable goal requires distinct ways of intervening, as well as a redefinition of healthy family functioning."

Traditional Family Therapy

The traditional approach recognizes that gender role is not synonymous with gender. There are family systems in which gender roles contradict gender: the wife may behave more like a "man" and the husband may behave more like a "woman." This situation would not be seen as problematic by a family therapist, unless the roles were rigid and caused internal and interpersonal distress. If the gender role involves power abuses, therapy would address the power issues. In other words, **the goal would be to change what can be changed rather than what is immutable** (e.g., unfair distribution of power rather than someone's sex).

Traditional family therapy respects the goals of the family system. This may or may not be true for the feminist approach, which focuses on equal power sharing within the family. It is conceivable that different levels of power sharing and gender role functioning may be desired by different family systems. This perspective was presented by McGoldrick (1982) in the different types of family systems that characterize various cultures; e.g., a devout Muslim wife might not question or be uncomfortable with a patriarchal organization prevalent in Islamic cultures.

The goal in traditional family therapy often is characterized by that which works for each case, not what should be. Education is often an important part of

therapy, but process and dynamics are the main focus. It is recognized that one cannot apply a "cookie cutter mentality" to all families. In general, family therapy intends to empower all members of the family, respectful of their developmental needs. This means that children do not benefit from the same type of power as adults.

Traditional family therapy posits that reality is co-created in a relationship. For example, a child who is rigidly assigned to the scapegoat role in the family often augments the rigidity by participating in negative recursive cycles with the parent. Another way of viewing a similar situation is that misbehaving children often serve a protective function in the family (Madanes, 1981). Their dysfunctional behavior keeps the family engaged in a predictable, if unhappy, way. Whether or not this is true is not as important as the powerfulness of using this type of relabeling in understanding family dynamics.

Traditional family therapists believe that it is not the therapist's responsibility to change society. The therapist should not behave as if he or she knows what the family needs; that is the business of the family to know and the therapist to attempt to help attain. **Traditional family therapy is flexible about the point of intervention, which means that whomever is most invested in change will be the most responsive to therapeutic guidance.** It is possible to effect systematic change, even when working with one client. The larger the part of the system involved in therapy, the greater the opportunity for stable and lasting change. For example, seeing a child alone rather than the child and the mother is less likely to effect change in the entire family; seeing the entire family together and facilitating positive interactions among all the family members will effect more stable change.

Another important emphasis of family systems therapy is the recognition that different family members have different developmental needs. It is not useful to focus on meeting only one person's needs; the emphasis in family therapy falls on the flexibility in roles. However, children's needs for stability and security should not be sacrificed to a parent's career or needs for personal development. Conversely, a parent's needs for self enrichment should not be sacrificed in favor of overemphasized nurturance of a child.

Wheeler, Avis, Miller, and Chaney (1985) presented a common family problem of a nagging wife and a withdrawing husband. A feminist family therapist "will begin to see 'nagging' as a behavior of powerlessness and 'withdrawing' as an exercise of power. This view will influence the therapeutic goals sought and the interventions selected." A family systems therapist most likely would not ascribe political meaning to the interactions before testing out each members' interpersonal dynamics. It is equally as likely that both members engage in their problematic behaviors with a perception of powerlessness. The husband's comment might be, "No matter what I do, it isn't good enough...so I just quit trying," whereas the wife might feel her nagging is the only way to ensure contact with her spouse. **A therapeutic goal of empowering both the husband and wife might be the most respectful and useful in this circumstance.**

A final response that family systems therapists might offer to the feminist perspective is the concept that some differences in power within the family are appropriate and necessary. Family therapists believe that children do not function well when they are on a power level equal with their parents. Because parents do not always agree, a rigid one-down position for women is problematic. However, the goal should be one of flexibility and compromise, not role reversal. Again, it would not be the role of the therapist to decide what is "politically correct" but to help the family heal its own system.

Differences Between Feminist and Traditional Family Therapies

In general, feminist and traditional family therapies tend to diverge with regard to family structure; gender significance; causality; influence of the past and present; class and ethnic differences; certain theoretical concepts; and biases in clinical practice. **Although both therapies strive for a systems approach that is nonpathologizing and oriented to the present, the feminist approach emphasizes the aforementioned concerns, which are outgrowths of the feminist critique of traditional family life and women's experience within the family.**

FAMILY STRUCTURE:

Hare-Mustin (1978) stated that "the American family as we know it from research and clinical practice is one in which the husband bears the main responsibility for the economic maintenance of the family and the wife bears primary responsibility for domestic work and child care." Also, "The nature of the family today is a consequence of the dramatic changes that took place during the nineteenth century, chief among which was the separation of work from the home. Where productivity was rewarded by money, those who did not earn money, such as women, children, and old people who were left home, had an ambiguous position in the occupational world."

The instrumental role for men and the expressive role for women that evolved were held up as normative by Parsons and Bales (1955) and even necessary for the well-being of individuals, the family, and society. Hare-Mustin (1978) made the point that the employment of women outside the home has not released them from the assigned expressive role that accompanies homemaking responsibility. Therefore, **employed wives labor longer than either employed men or full-time housewives.** The fact that child care is not easily available in the United States ensures that women cannot be released from their primary responsibility in the home just because they work. It is generally accepted that women continue to earn significantly less than men. It still appears that being a woman is seen by many as qualifying for domestic work, no matter what her interests, aptitudes, or intelligence. Egalitarian arrangements in which both parents share equally in domestic areas and work responsibilities are rare, despite the stated hopes of many adults.

THE FUNDAMENTAL NATURE OF GENDER:

Feminists assert that of primary importance in considering the family is the fundamental nature of gender as an "irreducible category of clinical observation and theorizing" (Goldner, 1985*b*) **similar in character to the importance of race and class. The feminist critique holds that the whole of human experience is gendered, as a result of the fact that in the family and in society a person belongs to one gender or another.** The important aspects of being gendered are subtly communicated and internalized from the moment of birth onward. The idea that one chooses to play particular roles is misleading; a person internalizes his or her gender and all it implies, including a greater measure of power and privilege afforded to men.

Following this line of reasoning, **the feminist critique holds that the family is weighed down by ideologic baggage.** Hare-Mustin (1978) pointed out that "it is only as the middle-class, nuclear family has begun to unravel and take on new forms that family therapists have come to recognize that we have taken a snapshot of white, middle-class family life in the fifties and mistaken it for a platonic model of family structure." Studies have shown that married women have a higher incidence of mental illness than men, but single women do not (Hare-Musting, 1978). According to a feminist approach, this observation

should lead family therapists to question the structure of the traditional family as it affects women.

The traditional family structure may be unwittingly reinforced by family therapists who see gender complementarity as important for the balance of the system. Goldner (1985*a*) pointed out that **"marital complementarity must be understood not only as a psychological arrangement between husband and wife but also as a phenomenon structured into intimate relations by the larger social context.** Whereas psychologically complementary relations can be fluid, with two people gracefully shifting hierarchical positions as the situation demands, socially complementary relations are rigid, resulting in fixed hierarchies organized around social categories such as 'gender.' These gender hierarchies then complicate the functioning of generational hierarchies, which family therapists have considered to be the core of family relations."

Role complementarity in the family system is most often defined by men. The feminist critique holds that "as in other unequal relationships, the dominant group defines the 'acceptable' roles for the less powerful, which are those activities like domestic work that the dominant group does not choose to do" (Hare-Mustin, 1978).

The feminist analysis faults family therapy for failing to incorporate seriously the effects of the status of women into the systematic equation. This oversight is described as a misunderstanding of women's problems in the family and leads to what feminists describe as "mother blaming." Wylie (1989) stated, "Hare-Mustin was the first to uncover what many now think was family therapy's dirty little secret.... Beneath the sanitized terminology about dysfunctional executive systems, enmeshment, and detriangulation, family therapists were still talking about mother as the enemy—a querulous, dependent, overcontrolling woman who emasculates her husband and emotionally stunts her children." Wylie went on to describe that in a survey of the four leading family therapy journals from 1978–1987, mother blaming had not decreased. According to the authors of the study, family problems were attributed to mothers twice as often as to fathers; the behavior of the mothers was described in much more pejorative and judgmental terms. One of the authors (Avis, 1985) stated, "Mothers just could not get it right." They were either overinvolved (i.e., nagging, overly permissive, intrusive, domineering, overprotective) or not involved enough (i.e., distancing, stony-faced, cold, cerebral, or overcontrolled). The authors also noted that in family therapy, the fathers often were brought in "to instruct, to supervise, and correct their wives in such 'masculine' talents as paying bills, balancing a checkbook, or disciplining the children, while mothers were never asked to share their particular expertise."

Other authors (Goldner, 1985*a*) pointed out that the origins of these attitudes are found in the social fact that mothering tends to be the sole responsibility of women. In modern societies, duties of motherhood also tend to be performed in isolation from the mother's female peers and relatives. Goldner wrote, "It is no wonder, then, that relations between mothers and children are supercharged, and since virtually every adult was raised by a woman, all of us are likely to retain exaggerated images of an all-powerful, fearsome, and enticing figure, who rendered us helpless merely by contrast." The contrast of which this author speaks is the overwhelmingly greater accessibility of mothers than fathers within the family, as well as within family treatment. It tends to be mothers who present the family for therapy. They are more readily accessible than fathers for evaluation, study, and questioning. They are there for the general public to see, raising their children. Thus, they are easy targets for blame. **In family therapy, the activity of mothers is most likely found as the fault of their children's problems.** However, mothers' inac-

tivity and fathers' activity in the family are found to be pejorative only at a chance level. Fathers' inactivity or lack of involvement with their children is even less likely than chance to be blamed.

Family therapists encourage fathers to be more active in the family. Goldner (1985*b*) commented that in family therapy settings in which mothers are not overtly blamed for their children's problems, they still may be dealt with negatively in the sense that "where Mom's real lacks are magnified by proximity, Dad's fantasized strengths are exaggerated by distance. In other words, Dad is interesting and special merely because he is different." Thus, **the feminist critique would fault more traditional family therapists for leaning over backwards to entice fathers into treatment and keep them there at the possible expense of the self-concepts of mothers.**

CAUSALITY:

Another difference between family therapy and feminist family therapy is the way in which they view causality. **Family therapists question whether cause is a useful concept: events within a system are viewed as circular, self-reinforcing, and homeostatic.** Therefore, oppression in a family system would be viewed as a cyclical pattern of interaction sequences between the participants. **Feminist family therapists view causality within the family as at least partly linear.** In other words, causes for some problems consist of events, institutions, and social norms that occur "a priori to their oppressive effects on women" (Libow, Raskin, & Caust, 1982).

INFLUENCE OF THE PAST AND PRESENT:

Libow, Raskin, and Caust (1982) stated that whereas **both approaches agree that context determines behavior**, "the family systems therapist's emphasis is on the here and now, the ways by which the system-maintaining mechanisms continually reincorporate the past into the present through reciprocal influence of family members on one another.... On the other hand, **the feminist therapist maintains a keen sense and an active analysis of external events, their historic and socially determined underpinnings, and subsequent impact on clients' lives.** Although the therapeutic work at hand may focus on the present, a deep sense of respect is maintained for antecedent causes and conditions that have helped shape the present."

CLASS AND ETHNIC DIFFERENCES:

Another dimension on which the two approaches differ is their response to class and ethnic differences. Just as feminists cite the importance of dealing with sex-role–related characteristics in therapy, they also point out the importance of confronting the difficulties inherent in racial and class characteristics that may be oppressive to clients. **Sex, race, and class are seen as variables that must be taken into account to effect change in the larger system that impacts on the family. Thus, it may be said that a feminist approach attempts to work on change within the larger system in which the family functions.**

A more traditional systems approach certainly would take class and racial characteristics into account but, unlike feminist therapy, would not confront these characteristics in a political or social effort. **Feminists believe that in not viewing the family in the context of the larger system, family therapists tend to ignore broader patterns of dysfunction and fail to notice the relationship between social context and family dysfunction.** James and McIntyre (1983) and Taggart (1985) pointed out that by taking the family out of its historical context, systems theory also blinds the therapist to the historical roots of the family, including the impact of the industrial revolution on contemporary family structure and the gendered division of labor.

THE CONCEPTS OF CIRCULARITY, NEUTRALITY, AND COMPLEMENTARITY:

Feminists also have difficulty from time to time with the concepts of circularity, neutrality, and complementarity. Feminist therapists tend to believe that notions of circularity that imply that all family members behave in a never-ending repetitive dance for which they all bear responsibility is akin to a sophisticated version of "blaming the victim." The concept of circularity in cases of incest and spouse abuse subtly removes responsibility from the perpetrator while implying that the other family members (especially the mother) are co-responsible and in some way perpetuate the pattern that results in violence and abuse (Bogard, 1984). Taggart (1985) mentioned that **systemic notions of neutrality emphasize that all parts of the system equally contribute to the production and maintenance of problems and thus render invisible differences in power and influence between different members of the family.** Therefore, questions of individual rights and responsibilities tend to disappear. Goldner (1985*a*) writes that **the concepts of sex roles and complementarity "obscure aspects of power and domination by appealing to the prettier, democratic construct of 'separate but equal.'"**

BIASES IN CLINICAL PRACTICE:

The American Psychological Association Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice (1975) found the following four biases in clinical practice: (1) Fostering traditional sex roles; (2) unfair expectations for women and the devaluation of women; (3) sexist use of psychoanalytic concepts; and (4) responding to women as sex objects. In addition, the Task Force found the following five biases particularly prevalent among family therapists: (1) Assuming that remaining in a marriage would result in better adjustment for women; (2) demonstrating less interest and sensitivity to a woman's career than a man's; (3) perpetuating the belief that a child's problems and child rearing are primarily women's responsibilities; (4) exhibiting a double standard regarding a wife's versus a husband's extramarital affair; and (5) deferring to a husband's needs over those of a wife. **Such problems in family therapy are echoed by many feminists, who fear that a typical systems approach to family therapy unwittingly accepts, models, and even strengthens oppression within and without the family.**

It is suggested that with the feminist approach, the therapist uses himself or herself in a way different from more traditional family therapy, including behaviors such as self-disclosure to emphasize the commonality of gender-related problems, the modeling of assertively instrumental and affective responses, and the open expression of the therapist's beliefs regarding the exercise of personal power. Again, the therapist attempts to take a collaborative problem-solving approach with the family and avoids wearing the hat of "the expert." Piercy and Sprenkle (1986) provided a thorough and practical set of skills that may be used by the feminist family therapist to develop and maintain a working alliance between the family and the therapist, to define the problem, and to facilitate change.

CASE PRESENTATIONS:

Two case examples serve to describe the potential differences between traditional family therapy and feminist family therapy.

Case 1

A woman presents to the therapist in search of support and validation for her deeply

felt desire that she is stifled in her marriage. The woman feels that the solution to her problem is obtaining a divorce, despite the fact that there is no report of abuse within the marital relationship and the couple has two school-aged children.

A traditional family systems perspective would emphasize the need to obtain information and involvement from all family members. Initially, the couple would be interviewed; at a later time, the therapist would involve the children to assess the impact of the marital distress and/or their mother's distress on them. Emphasis would be placed on the integrity of the family unit, and, if possible, the family would be encouraged to explore all options that would allow the mother's needs to be met within the context of the family. This may involve family therapy techniques such as **reframing**. For example, the client's desire to obtain a divorce might be reframed as a developmentally appropriate desire for change in her life. Another common approach would be to **identify each family member's goals** and to engage the family in actively working out compromises respectful of the value of all members in the family.

With a feminist approach, the first step would be to validate the woman's desire for change. Therapy would seek to empower her to feel free to make difficult decisions in a responsible manner. **She would be encouraged to understand her situation in light of gender and role difficulties. She would be asked if she wanted to incorporate her family in the therapy; it would not necessarily be assumed that she would wish to do this or that therapy would be more effective if the family were the unit of treatment.** If she were able to have her self-stated needs met within the family context, she would be encouraged to do so. However, if her roles within the family were oppressive to her development and desires, she would be supported in her decision to pursue a life outside the family unit. The decision as to whether she wished to remain married or to continue to assume the major role in child rearing would be hers to make, and she would be supported in her decision.

Case 2

A woman with two children from a previous marriage seeks therapy after discovering that her current husband has been sexually molesting her 9-year-old daughter for the past 6 months. The legal requirements for reporting have been met and disposition of the case is unclear. During the first session, when therapy goals are discussed, the mother states that she wants to help her daughter and overcome strong feelings of guilt; she also hopes to resolve her confusion about her relationship with her husband. She states that she still loves him and thinks she still wants to live with him, but does not believe she can ever forgive him.

The traditional family systems approach would strive to pinpoint her goals. For example, ways of helping the daughter might include ensuring that she feels safe and clarifying the generational roles: the mother will take care of the child and the child is *not* responsible for what her stepfather did to her. **Following the concept of circular causality, a way of helping the mother with her guilt would be to clarify the concept of the role of the perpetrator; the therapist would help the mother identify patterns of her own behavior that inadvertently may have facilitated the victimization of her daughter**; e.g., ignoring her own uneasy suspicions when she saw her husband behave in ways she felt were inappropriate; the paucity of sexual involvement between her husband and herself; and her husband's abusive use of alcohol. To help her clarify the marital relationship, it may be advisable to see her and her husband together so the marital process may be observed. At a later time, it may

be beneficial to have all the family members seen together so that honest communications about the damage done and hopes for future family healing can be expressed.

The feminist approach to dealing with such a case would be **similar to the traditional family approach in the initial stages**; i.e., dealing with the legal aspects of the case, clarifying goals, and protecting the child. **The mother and the child most likely would be seen together in the initial stages of therapy.** Information about sexual abuse, the innocence of the daughter, and the responsibility of the perpetrator would be emphasized. **A major difference from traditional family therapy would be that the feminist therapist would begin to emphasize the educational component regarding gender, sex role, and unequal power balances from the beginning of therapy throughout the process.** The mother would be questioned as to whether she wanted to stay in her marriage, assisted in clarifying her role in the marriage and the family, and encouraged to seek an egalitarian power balance between herself and her husband. She would be assisted in clarifying whether this was, in fact, possible within the context of her marital relationship and encouraged to make assertive and proactive decisions regarding her needs and the needs of her daughter. She might be encouraged to attend a women's support group; the daughter also may take part in therapy and/or a group for young survivors of sexual abuse. **Seeing the family together in therapy would not necessarily be of primary importance, as long as the child was being protected and the mother was learning to behave assertively and work on her own empowerment.**

Similarities Between Traditional and Feminist Family Therapy

Although the two approaches appear to have many differences between them, there are many family systems therapists who bring a feminist consciousness to their work. Likewise, there are many feminist therapists who practice family systems therapy. (From time to time, one might even wonder which approach is which!) **Specific approaches observed in a feminist practice might include:**

- **Discussing gender issues** (e.g., money, power, child care, housework, the division of labor) during therapy and being direct about the therapist's own beliefs
- **Relabeling deviance and redefining normality so as to highlight women's strengths**
- **Using Bowenian family systems theory to aid women in defining themselves independently of what others expect them to be**
- **Focusing on the needs of women as individuals as well as on the needs of the relationship**
- **Avoiding conjoint therapy in cases of wife abuse**
- **Empowering women in a wide variety of ways both inside and outside therapeutic settings** (Piercy & Sprenkle, 1986)

Wheeler, Avis, Miller, and Chaney (1985) emphasized the importance of helping women express anger effectively and assertively; using role playing to help clients practice new sex-role behaviors; teaching women to assess and meet their own needs; teaching men to recognize and express their feelings; and instructing men in how to respond effectively to their families' emotional and nurturing needs.

Both approaches to family therapy hold that the

social context in which people exist is a prime determinant to behavior. Each rejects the medical model as an explanation of individual differences and the assumption that people have certain problems because something is wrong with them ("blaming the victim"). Both approaches also attempt to avoid the use of psychiatric labels and traditional diagnoses; employ the use of relabeling or reframing of client difficulties; and use modeling as an important tool. In terms of assessing change, both value change that is observable, concrete, and in the present. **Although the concept of power may be used differently by the two approaches, both view it as an important dimension of experience. Both approaches are existential in nature: They emphasize the present and the importance of the client's self-reported experience as opposed to what the therapist "thinks" he or she has done in therapy.**

The family systems approach can be used advantageously by feminist family therapists because it allows the therapists to break from the traditional intrapsychic mode to more creative, nonstereotypical ways of working. The therapist is required to be proactive and to model instrumentality in his or her behavior. The family systems approach permits clinicians to deal with child clients with a more hopeful, open attitude; the troubled child is no longer seen as the identified patient but as an important part of the entire system. Thus, the therapist can help the family create change in the entire family, rather than seeing only subsystems of it.

Libow, Raskin, and Caust (1982) stated, "Finally, family systems therapy is consistent with a feminist orientation to social change. As feminist principles and family systems therapy concepts and tools begin to blend and find their place as useful theoretical companions, the therapist can approach families with strategies for change that reflect more flexible role arrangements capable of improving the lives of all members of the family"—and, the feminists might say—society as well.

REFERENCES

American Psychological Association Task Force (1975). Report of the task force on sex bias and sex-role stereotyping in psychotherapeutic practice. *American Psychologist, 30*, 1169–1175.

Avis, J. M. (1985). The politics of functional family therapy: A feminist critique. *Journal of Marital and Family Therapy, 11*, 127–138.

Bograd, M. (1984). Family systems approaches to wife battering: A feminist critique. *American Journal of Orthopsychiatry, 54*, 558–568.

Caust, B. L., Libow, J. A., & Raskin, P. A. (1981). Challenges and promises of training women as family systems therapists. *Family Process, 20*, 439–447.

Goldner, V. (1985*a*). Feminism and family therapy. *Family Process, 24*, 31–47.

Goldner, V. (1985*b*). Warning: Family therapy may be dangerous to your health. *Family Therapy Networker, 9*, 19–23.

Hare-Mustin, R. T. (1978). A feminist approach to family therapy. *Family Process, 17*, 181–194.

James, K., & McIntyre, D. (1983). The reproduction of families: The social role of family therapy. *Journal of Marital and Family Therapy, 9*, 119–129.

Libow, J., Raskin, P., & Caust, B. (1982). Feminist and family systems: Are they irreconcilable? *American Journal of Family Therapy, 10*(3), 4–10.

Madanes, C. (1981). *Strategic family therapy*. San Francisco: Jossey-Bass.

McGoldrick, M. (Ed.). (1982). *Ethnicity and family therapy*. New York: Guilford Press.

Parsons, T., & Bales, R. (1955). *Family, socialization, and interaction process*. New York: The Free Press.

Piercy, F., & Sprenkle, D. H. (1986). *Family therapy sourcebook* (pp. 213–242). New York: Guilford Press.

Rice, D. G., & Rice, J. K. (1977). Nonsexist 'marital' therapy. *Journal of Marriage and Family Counseling, 3*, 3–10.

Rowbotham, S. (1973). *Woman's consciousness, man's world*. Middlesex, UK: Penguin.

Simon, R. (1984). From ideology to practice: The Women's Project in Family Therapy. *Family Therapy Networker, 8*(3), 28–32, 38–40.

Taggart, M. (1985). The feminist critique in epistemological perspective: Questions of context in family therapy. *Journal of Marital and Family Therapy, 11*, 113–126.

Wheeler, D. (1985). The fear of feminism in family systems. *Family Therapy Networker, 9*(12), 54.

Wheeler, D., Avis, J. M, Miller, L., & Chaney, S. (1985). Rethinking family therapy education and supervision: A feminist model. *Journal of Psychotherapy and the Family, 1*(1), 53–71.

Wylie, M. S. (1985). The mother knot. *Family Therapy Networker, 9*(12), 44.

Questions Based On This Lesson

13. Which of the following would not be considered a negative bias by the American Psychological Association Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice?

    A. Telling a wife that she absolutely would be better off remaining in her marriage than leaving her husband

    B. Glossing over a husband's affair while emphasizing the negative aspects of a wife's affair

    C. Suggesting that the causes of a wife's dilemmas might be partly political in nature

    D. Focusing on the wife's role as an object for the husband's sexual desires

14. Compared with a traditional family therapist, a feminist family therapist would consider which one of the following concepts as the most appropriately relevant to therapeutic work?

    A. Neutrality

    B. Causality

    C. Complementarity

    D. Circularity

15. In the case of a woman who learns that her husband has been sexually abusing her daughter:

    A. Both feminist and traditional family therapies would emphasize the educational component regarding gender, sex roles, and unequal power imbalances from the initial stages of therapy

    B. A therapist employing the concept of circular reasoning would help the mother identify patterns of her own behavior that inadvertently may have facilitated the victimization of her daughter

    C. The feminist approach to family therapy would deal with legal aspects of the case in a markedly different manner as compared with a traditional approach

    D. The feminist therapist would always establish obtaining a divorce as the wife's primary goal of therapy.

16. Which of the following is not a similarity between feminist and traditional family therapies?

    A. Emphasizing action and behavioral change

    B. Viewing men as victims of a sexist culture

    C. Emphasizing social context as a prime determinant to behavior

    D. Using reframing and relabeling to shift the emotional perspective of a situation

Directions in Marriage and Family Therapy © 1994, The Hatherleigh Company, Ltd.
All rights reserved. Not to be reprinted without permission of the publisher.

Special Program Coordinators: Dennis A. Bagarozzi, PhD; Frederic Flach, MD

Editorial Board of Consultants: James Alexander, PhD; Stephen Anderson, PhD; Judith I. Bagarozzi, MS; Insoo Kim Berg, MSSW; William J. Doherty, PhD; Craig Everett, PhD; Charles Figley, PhD; Alan S. Gurman, PhD; Harvey Joanning, PhD; Florence Kaslow, PhD; James F. Keller, PhD; Luciano L'Abate, PhD; Pieter le Roux, PhD; Howard Liddle, PhD; Mel Markowski, PhD; Fred P. Piercy, PhD; Lynda Dykes Talmadge, PhD

Managing Editor: Debra E. Cermele

Associate Editor: Steven L. Pessagno

Directions in Marriage and Family Therapy is a continuing education program published by The Hatherleigh Company, Ltd., 420 East 51 Street, New York NY 10022. For additional information, please call 800-367-2550 or 212-355-0882 (outside the US).

Directions in Marriage and Family Therapy

VOLUME 2 • LESSON 5

Family Caregiving of the Elderly

Juanita L. Garcia, EdD, and Jordan I. Kosberg, PhD

Dr. Garcia is Associate Professor, Department of Gerontology, College of Arts and Sciences, University of South Florida, Tampa, FL, and Visiting Scholar, Department of Psychology, Concordia University, Montreal, Quebec.

Dr. Kosberg is Philip S. Fisher Professor and Director, The Centre for Applied Family Studies, School of Social Work, McGill University, Montreal, Quebec.

VOL. 2, NO. 5

1994

KEY POINTS

- An increase in life expectancies for elderly persons and a decrease in the rate of deaths from heart disease and strokes are but two factors that, with their combined effects, are making family caregiving of the elderly increasingly difficult. Not only are older adults (who represent a growing proportion of the population) living longer and with more impairments, but a decrease in birth rates is creating a situation in which there are less young family members to care for elderly dependent family members.

- The majority of family caregivers are women. However, this dynamic is changing as well, with an increasing number of women entering the work force. To be sure, the proportion of men caregivers is on the rise. However, this does not mean that working women are being relieved of the burden associated with caregiving; in fact, they usually must still deal with work-related and domestic pressures and face the possibility of reducing employment from full-time to part-time.

- Inevitably, relationships between family members are strained over the care of an elderly dependent relative. The dependent relative might have been a child or spouse abuser. Family members might bicker over how responsibility for care (and its cost) should be divided among them, in who's home the care should be given if the relative is not institutionalized, and how exactly care should be given.

- In addition to intervening in cases of family conflicts regarding the logistics of caregiving, family therapists can provide help for caregivers who are emotionally taxed (i.e., by depression, guilt, anger, regret) by the caregiving process.

- The first step to intervention is determining the motivation of caregivers. This way, the therapist can discern the reasons for the quality and quantity of care. For example, is the caregiver providing care out of a sense of guilt or of love for the dependent elderly person?

- It is also important for therapists to use diagnostic tests to assess the mental status and cognitive of abilities of family members who are under duress. Assessment is ongoing and can help the therapist determine what type of intervention is appropriate, be it support groups, educational interventions, clinical interventions, and/or the use of community resources.

Introduction

Family care has been the normative mechanism for the care of the elderly throughout history and has been supported by both social custom and religious admonitions to "honor thy father and mother." Yet, over time, changing values and economic factors have made family caregiving of the elderly increasingly difficult.

Numerous changes in contemporary society have affected the need for family caregiving and the ability of families to provide such care for older family members (Biegel, Sales, & Schulz, 1991). Such changes include **an increase in life expectancy, resulting in an aging population**. In addition, there has been a **decrease in the rate of deaths from heart disease and strokes as well as longer survival rates for cancer**. Thus, **more older persons are living longer with greater impairments** (and greater need for assistance in performing activities of daily living).

Along with the growth in the number of elderly has been **a decrease in birth rates, resulting in both a growing proportion of elderly and a reduction in the proportion of younger family members**. Changes in the family structure that affect traditional caregiving responsibilities for elderly relatives result from **increases in divorce rates, serial marriages, childless couples, and homosexual relationships. Perhaps the greatest influence on caregiving patterns has been the emancipation of women—the traditional care providers for the elderly—from the home.**

Yet, family care continues to be seen as a major mechanism to delay costly institutionalization (AARP, 1988) and to relieve government of the expense of caring for the elderly (Kosberg & Garcia, 1991). Changes in health care reimbursement policies and early hospital discharges of geriatric patients (determined by diagnosis-related groups [DRGs], which set the time for a patient's release under the Medicare program), have resulted in the increased possibility of family care for impaired persons (Coulton, 1988).

Those in the helping professions, especially family therapists and clinical psychologists, increasingly will be involved with family members who face challenges in the provision of care to elderly relatives, as well as with those family members who do not wish (or are unable) to provide such care.

Overview of Caregiving

FORMAL RESOURCES:

In general, caregiving to the elderly can be divided into **formal and informal systems. The *formal service system* includes community services and agencies, which are bureaucratically organized and funded by government or private philanthropy**. Such services are **delivered by trained professionals** and provide medical, legal, financial, nutritional, transportation-related, and mental health support to caregivers.

Formal services are a relatively **new addition to caregiving**. They have been established and organized by modern communities to compensate for gaps in care—when the family is not available or cannot fulfill its traditional caregiving functions.

INFORMAL SOURCES:

***Informal caregiving* of family members has been the traditional method by which the needs of the elderly have been met and is provided by family, friends, and neighbors.** This system ostensibly evolves naturally (in response to family needs). Although it appears less organized than the formal system, the informal system is believed to be such an effective mechanism (and much preferred over formal mechanisms) that its existence has been taken for granted, and relied upon, by aging and aged family members.

However, the tradition of family caregiving has been seriously challenged not only by societal changes, but also by the ever-increasing complexities of human relationships. Clinicians, service providers, and researchers are attempting to understand better the changes that occur in the caregiving situation and the varying interpretations by family members and elderly relatives that may lead to familial conflicts.

Clearly, not only are there changes in the perception of family responsibilities between generations, but also with regard to future relationships between caregivers and the care recipients (Litvin, 1992). For example, **caregivers (in contrast to care recipients) tend to be more optimistic in viewing the health conditions and social participation of the elderly; they also underestimate health care needs.** Such perceptions tend to "protect" caregivers; that is, they reduce the "need" for care and the "guilt" for not providing more care to an elderly relative (Allan, 1988; Brody, 1990).

A decline in intrafamily interaction leads to perceived (or actual) increases of conflict and stress for the caregiver. **Support to caregiving families will be most effective when there is a specific response to the personal and familial meanings of the caregiving situation.** As will be discussed later, professional interventions should be flexible, because one set of interventions will not work with all families.

Review of the Literature

Research has found that **caregivers for the elderly are generally family members, especially women (wives, daughters, daughter-in-laws, sisters) who are middle-aged and married** (Brody, 1981; Cantor, 1983; Cicirelli, 1983; Cicirelli, 1988; Horowitz, 1985; Kosberg & Garcia, 1991; Shanas, 1979; Stoller, 1983; Stone, Cafferata, & Sangl, 1987). Nonetheless, **the number of male caregivers for elderly persons has been increasing** (Brubaker & Brubaker, 1992; Horowitz, 1985; Stoller, 1983). One third of caregivers are 65 years of age or older. Most caregivers are spouses, one third are adult children; one fourth are other relatives and nonrelatives (Stone et al., 1987).

It is estimated that **one third of caregivers have neither formal nor informal help**. Caregivers from lower socioeconomic backgrounds report lower levels of health than do the general population. One fifth of caregivers have children under 18 living at home.

Almost **one third of caregivers are employed outside the home** (AARP, 1988), and **one fifth encounter conflicts in combining caregiving and work**; one third rearrange work schedules, and one fifth work fewer hours and take off work without pay (Neal, Chapman, Ingersoll-Dayton, & Emlen, 1993). About one tenth of caregivers report quitting work to be available to provide needed care to an elderly relative. Approximately **two fifths of employed caregivers report losing time, money, and/or benefits at work due to caregiving responsibilities** (Brody, 1990).

Research also indicates that caregivers need information on medicine, general health care, and available social services. One third report a need for emotional support and respite. Thus, studies have shown that families provide significant amounts of assistance while juggling competing demands. Caregiving responsibilities—coupled with lower income and lower self-reported health—suggest a significant need for supportive services and professional counseling and intervention.

ACTIVITIES OF CAREGIVERS:

Activities can range from the provision of total care for an elderly family member to assistance in one or two daily activities (Cantor, 1983; George & Gwyther, 1986). The family (generally the primary caregiver) must perform the following activities for an elderly dependent relative: cook, clean, nurse, wash, transport, supervise mobility, oversee administration of medications, help

with toileting (when incontinent), exercise, and feed—among other things (Lubkin, 1986). In addition to such instrumental tasks in caregiving are the affective ones, such as the provision of concern and affection. In summarizing the **social and psychological problems** faced by caregivers while assuming the major responsibility for keeping the relative at home, Strauss and coworkers (Strauss, Corbin, Faberhaugh, Glaser, Mainos, Suczek, & Weiner, 1984) list **eight concerns: preventing and/or managing medical crises, controlling symptoms, carrying out the prescribed regimens, dealing with social isolation related to home care, adjusting to changes in the course of a disease or disability, normalizing interaction with others and lifestyles, funding the care—drugs, treatments, services—despite reduced or complete loss of payment, and confronting psychological, social, and familial problems.**

EFFICACY OF CAREGIVERS:

Studies have attempted to measure the effectiveness of informal caregiving by family members and have reported **mixed results** with regard to caregiving competence (Noelker & Townsend, 1987; Townsend & Noelker, 1987). In one study (Kosberg & Cairl, 1991), competence was measured and the findings disclosed differences ranging from low to high, with the majority of 96 family caregivers of Alzheimer's disease patients demonstrating moderate levels of competency. (Areas of competence pertained to meeting the medical, social, psychological, and safety needs of the demented relatives.)

Caregiver competency, as well as efficacy of care, are **related to caregiving burden**. Awareness of this burden has emerged from studies on the great demands placed on families caring for mentally retarded, mentally ill, and, more recently, demented relatives (Brubaker & Brubaker, 1989; Zarit, Reever, & Peterson, 1980). However, family burden has also been found to result from care given to persons with less dramatic health problems. Indeed, the more healthy and active a care recipient may be, the greater the likelihood of "fighting" a growing vulnerability and dependency (and the caregiver). In addition, the cognitive impairments of a physically healthy person can cause burdens, no less than the caregiving burdens from physical impairments.

Caregiving research originally focused on the global needs of family caregivers in hopes of increasing the level of care and/or reducing the burden. Efforts to conceptualize caregiver burden more effectively has led to development of quantitative measures of burden (Kosberg & Cairl, 1986; Zarit & Zarit, 1982). Research on the correlates of caregiving burden have determined the severity of an illness (thus, the greater the responsibilities), the amount of patient change, and the suddenness of a problem's onset (or the awareness of a problem). **Demographic variables associated with caregiving burden include gender (female caregivers have greater stress), role relationship (spouses and others who live with the impaired older person have higher levels), those in poorer health themselves, younger age (such persons display greater distress), socioeconomic status (those with higher income levels initially had greater stress, whereas those with lower income levels had long-term needs with fewer resources and greater stress later on). Life status variables associated with burden include the existence of other stresses, such as poor health, conflicting demands, and economic hardships.**

Lower levels of burden are associated with marital cohesiveness and positive marital communications. Social support studies have shown mixed results. Some indicate that the informal support system guards against caregiving burden, whereas others have noted a positive relationship between the extent of the social support system and the sense of perceived burden. The lack of conclusive findings between burden and the participation of family members merely reflects the idiosyncratic nature of the dynamics for each caregiving situation.

Motivations

It is important to determine the motivation of caregivers. Such an awareness should give insight into the reasons for the quality and quantity of care given to an elderly person and provide clues for necessary professional intervention (in cases of adversity to the older person or stress to the caregiving family or family members).

Batson and Coke (1983) have discussed two general types of motivations: **negative and positive**. The former might involve an **anticipation of reward (expectations of payment, gaining social approval, avoiding censure** (Reis & Gruzen, 1976), **receiving esteem in exchange for helping,** (Hatfield, Walster, & Piliavin, 1978) **complying with social norms,** (Berkowitz, 1972) **seeing oneself as a good person,** (Bandura, 1977) **and avoiding guilt** (Brody, Litvin, Hoffman, & Kleban, 1992; Hoffman, 1982).

Positive motivations for providing care result from feelings of love, respect, and loyalty. The desire can be based upon genuine empathy and altruism; some caregivers are able to adopt the perspective of another and desire to alleviate the suffering of another person. Although not empirically based, it can be assumed that **an ability to empathize is based on kinship, similarity, prior interaction, and attachment**—all of which are pertinent to intrafamilial situations. Yet, such considerations can also lead to higher levels of distress among caregivers (Cantor, 1983; Horowitz, 1985), again underscoring the complexities in caregiving with elderly family members that make arrivals at definitive conclusions difficult (if not impossible).

In a more pragmatic view, **family care may be chosen due to a lack of alternatives**; the motivation to provide care may result from a belief that if care is not provided to an elderly relative, institutionalization will be necessary. Furthermore, professionals often will seek to influence family members to assume caregiving responsibilities. This may be due to the fact that such a solution to the placement problem of an older patient is perceived to be the easiest solution and/or to the fact that the professional's own value system supports filial responsibility.

Problems with Family Caregiving

Caregiving responsibilities are not limited to caring for a live-in older relative. The provision of care to the elderly person in his or her separate home may require more time, effort, and cost to the caregiver. To be sure, there are several potential problems for those who wish to take on caregiving responsibilities for any elderly relative.

ECONOMIC ISSUES:

Some families and family members are under economic pressures caused by unemployment or underemployment. There may be additional real (or imagined) expenses resulting from the provision of direct or indirect care to an elderly relative. It is known that intrafamily problems (including child and spouse abuse) often result from economic pressures within the family.

GENDER ROLES:

In the past, women were the major caregivers of family members, because of their socialization and also because they generally remained at home. As a result of the women's movement, however, they are increasingly seeking careers outside the home. **Unfortunately for women, even though they are more likely to be working outside their homes, they maintain the major responsibility for caregiving within their families. Dual pressures from the work place and the home result** (Neal et al., 1993), **including an increased possibility of having to switch from full-time to part-time employment (or to leave the job market altogether).**

SOCIAL DISRUPTION:

Individuals and families have social lives that can be adversely affected by caregiving responsibilities. The freedom to come and go, to invite friends over to one's home, to leave the home for a long-weekend outing all may be precluded by the need to care for an especially ill, impaired, or confused elderly relative.

PHYSICAL PROBLEMS:

The severity of physical and/or mental problems of an elderly relative may adversely affect the ability of family members to meet his or her needs. On the other hand, health of the caregivers themselves will determine their ability to meet the needs of the dependent elderly person and the likelihood that the caregiver will incur physical or psychosomatic problems resulting from the provision of care.

FAMILY RELATIONSHIPS:

There is an assumption that **family care of an elderly person may be an extension of a past history of positive regard for each other (reciprocity) over the years**. And, of course, situations exist in which a **history of poor interpersonal relationships** is evident. **The dependent elderly relative might have been a child or spouse abuser, a neglectful father or husband, or had a long history of poor relationships with those on whom he or she is now dependent. Clearly, caregiving responsibilities for such persons will be given ambivalently, if not grudgingly (and, perhaps, harshly).**

PHYSICAL BARRIERS:

The **physical structure of the home may be incongruent with the needs of the care recipient**. Some elderly use walkers or wheelchairs, some have ambulation problems resulting in an inability to climb stairs. If a home is not located near public transportation or needed public or private conveniences, the care recipient can become more like a "prisoner" within the home and more dependent upon family caregivers. Finally, the need to care for an elderly relative within one's home may result in **overcrowding or dislocation of family members** (i.e., moving children out of their rooms) or the need to share rooms.

VALUES AND EXPECTATIONS:

There is no reason to believe that caregivers and care recipients share common expectations toward their rights and responsibilities. As opposed to the responsibility that parents have for their children, there are no clear-cut policies that dictate the responsibilities of family members (especially adult children) toward elderly relatives. **Discord from discrepancies between generations may result in a range of emotions from guilt to anger** (Garcia & Kosberg, 1992).

Moreover, some elderly relatives have been labeled as provocateurs (Kosberg & Cairl, 1986); they are overly demanding, and unappreciative of the efforts of their caregiver(s). Such persons can make caregiving exceedingly difficult for those caring for them.

Consequences of Family Caregiving

As reported in two national surveys (AARP, 1988; Cantor, 1983), **consequences for providing care can include *decreased* health, income, freetime, and privacy, as well as *increased* pressures and isolation**. Moreover, negative emotions (anger leading to depression or hostility) may result from the caregiving experience. In fact, however, there can be both positive and negative consequences for family members who assume caregiving responsibilities for elderly persons.

POSITIVE FEATURES:

Colerick and George (1986) found caregivers can realize **positive feelings of accomplishment and self-satisfaction resulting from their efforts in providing**

care to an elderly loved one. Hooyman and Lustbader (1986) found an increase in life satisfaction. Indeed, for some relatives, providing care to another is the major role that they perform, and when the role ends, (i.e., a child growing up or the death or institutionalization of an elderly parent or spouse), there can be emotional consequences for the former caregiver who loses his or her major role.

Fitting, Rabins, Lucas, & Eastham (1986) found improvements in some spousal relationships that resulted from the caregiving role. Also, Lewis and Meredith (1988) reported on the reaffirmation of the "feminine identity" that resulted from the provision of care to an elderly relative.

FAMILY DISHARMONY:

Research has found that the needs of an elderly relative may result in serious family disharmony: **members of the family bicker about the sharing of responsibility; the perception arises that family members are shirking their responsibility; or an attempt is made to set a financial *quid pro quo* for a relative who is unable or unavailable to share in the caregiving responsibility** (perhaps due to living a great distance away). This disharmony can result in **bitter intrafamily feelings. Worse yet, negative feelings may become focused upon the elderly relative.**

INEFFECTIVE CARE:

In some instances, caregivers (no matter how hard they try) are unable to meet the needs of the elderly person. This may be the result of being unable to afford the necessary health resources (equipment or home health care visitors), or it may be a result of being physically or **emotionally unable to meet the daily needs of cleaning, bathing, toileting, feeding, or cooking for the elderly person**. Indeed, as found by Kosberg and Dermody (1985), one third of discharged geriatric patients were cared for by a person (generally a spouse) who was as old and frail as the discharged patient. Clearly, caregivers—especially those who care for the most impaired persons—must have some degree of strength and physical dexterity to execute their duties.

ELDER ABUSE:

The ultimate adversity resulting from caregiving problems is elder abuse. Such adversity can include acts of omission (neglect out of ignorance or passive behavior) or acts of commission (physical or psychological abuse or active neglect). There are many explanations for why family members would abuse elderly relatives (Kosberg, 1988). But persons do have "breaking points." To paraphrase Garbarino (1947) (who wrote about child abuse): given the wrong set of circumstances, we can all be a child abuser (or an elder abuser). And **often when one faces personal or family problems, the focus of adverse emotions (anger, frustration, depression) is often turned to the perceived source of the adversity—the elderly person.**

Interventions

Given the demands and possible strains from caregiving to elderly persons, caregivers often also need attention from those in the helping professions, especially if the cared-for person is frail and dependent upon others for the performance of many tasks for daily living. The overwhelming and unrelenting needs of providing care (envisioned in the title of a popular book on caregiving to Alzheimer's disease patients, *The Thirty-Six Hour Day* by Mace and Rabins [1981]) has been recognized through the development of community resources (e.g., respite care, family caregiving support groups, and community day care centers).

Types of interventions commonly used for caregivers vary in frequency, duration, and intensity of involvement, because the caregiving situations vary significantly. But, in general, these intervention tech-

niques can be described as support group, educational, clinical (direct service), and specific community services. These interventions also vary on the basis of the level of involvement by a professional and can include the direct provision of clinical intervention, the formation and conduct of group efforts, and/or referrals to concrete community resources. However, **before interventions are planned, it is necessary to assess the caregiving situation**.

ASSESSMENT:

A number of tools have been devised to assess the mental status of elderly persons. **One such tool measures cognitive abilities: the Short Portable Mental Status Questionnaire** (Pfeiffer, 1975), which is brief and requires minimal training.

The assessment of affect is particularly important in working with the elderly, as **depression is not uncommon** in response to social loses or in conjunction with physical decline. **The Geriatric Depression Scale** (Yesavage & Brink, 1983) **is a reliable and valid measure consisting of 30 yes/no questions.**

Functional assessments can be made with instruments such as the **Katz Index of Activities of Daily Living** and the **Instrumental Activities of Daily Living**, both developed at Duke University (*The Older American*, 1978). These instruments focus on specific deficits, distinguish levels of needed assistance, and can translate readily into required services.

For effective intervention to occur, **assessment must be made of family members who are under duress** (Kosberg & Cairl, 1986; Kosberg, Cairl, & Keller, 1990), and one must **delineate the specific dimensions of caregiving burden** (George & Gwyther, 1986; Zarit, 1989). Tools such as Kosberg's Cost of Care Index (Kosberg & Cairl, 1986) help identify potential stressors in such areas as physical health, social functioning, and financial burden.

Social assessments include not only the caregiving family, but also the entire social network from which support may be available. The results of such assessments can help determine what specific aid will be required as well as the **division of labor (responsibility)** between the family members.

Assessment is not a one-time event. The family members need updates on cognitive and physical levels of functioning of the care recipient in order to identify any necessary changes in caregiving. Through ongoing professional contacts, the caregiving family is emotionally reinforced in their efforts. **The rewards of family care may be few but can be extremely significant (i.e., family cohesiveness, the expression of love, duty and pride).** The burdens of caregiving can be great and result in both **objective pressures (time, energy, expense)** and **emotional pressures (anger, guilt, embarrassment, sense of helplessness, grief, depression, feelings of isolation, loss of control). The identification of such consequences is the first step to intervention.**

SUPPORT GROUPS:

The support group is **designed to offer emotional support, information, and, hopefully, improve coping skills by using guest lecturers and by sharing coping strategies with group members. These groups can be led by professionals or peers.** They emphasize the **sharing of feelings and experiences**, reinforcing the idea that the caregiving family (or individual) is not alone in the struggle. **Professionally led groups tend to be time-limited (8–15 sessions), whereas peer-led groups usually are ongoing (as long as need and energy remains).** At times, professional efforts are used to start a group, then are continued by indigenous peer leaders who emerge from within the group. Groups are formed within the structure of formal service settings (from private practice to family service agencies).

Research has found that **middle- or upper-class whites are more likely to use support groups than are nonwhites and/or minority group members**. To attend a support group, caregivers must have someone to relieve them from the care of the elderly relative and have transportation (or access to transportation). Such considerations and preconditions must be addressed.

EDUCATIONAL INTERVENTIONS:

Educational group interventions utilize professionals in an information giving/teaching/training capacity. The aim is to **transmit and improve caregiving skills**. These interventions can be divided into **three types: (1) Cognitive information only (i.e., how to bathe a frail patient); (2) cognitive information with self-enhancement (i.e., how to bathe an older person with attention to the caregiver's feelings of competence); and (3) behavioral management skills with or without self-enhancement (i.e., social-skills training, such as assertiveness training or building a social network).**

Such efforts involve the professional provision of information and training skills. Educational efforts **vary greatly in purpose and format.** It has been found that **information is better received in an interpersonal setting than received through less direct means (i.e., by mail)**. The considerations in the use of educational types of group intervention are the same as for support groups.

CLINICAL INTERVENTIONS:

Clinical interventions, or direct services, include a variety of intervention modalities such as **individual or group counseling/therapy, behavioral/cognitive stimulation, general psychosocial interventions, and specific case management**. Briefly, these various interventions can include the following activities:

- **Counseling** can involve any number of theoretical approaches. It may be lengthy and quite comprehensive or brief and more intensive in its focus upon the dynamics within the caregiving family, conflicts between an elderly couple, or problems (i.e., depression) faced by the primary caregiver.
- **Cognitive/behavioral stimulation** may focus upon specific behavioral changes needed to increase awareness or improve communication skills. Such efforts usually are **task-orientated and time-limited** and can be directed at either the caregiver or the care recipient.
- **Psychosocial interventions** include a broad range of services and can be grouped by approaches that usually involve **comprehensive assessments** that are followed by a range of treatment recommendations (from the institutionalization of older person so as to salvage the family, to securing medications for caregivers, to family counseling or better distribution of caregiving tasks) and follow-up treatment (Biegel et al., 1991).
- **Case management** is a new form of intervention that is frequently misunderstood. Although often undertaken by paraprofessionals, case management can involve a clinical psychologist who undertakes the in-depth assessment of patient problems, **develops a plan of action** (which may include therapeutic interventions), **monitors the progress of the patient, and determines a time for the intervention to end.** In addition, the case manager may advise and utilize appropriate formal services (e.g., community resources) in support of the caregiver or caregiving family.

USE OF COMMUNITY RESOURCES:

Professionals who work with family caregivers may need to use a variety of community resources when available. And even when available, there may be eligibility criteria or waiting lists for services—a situation that requires creativity and perseverance. Many possible community resources are available: **Meals-On-Wheels, Senior Companions, Supplementary Social Insurance**

(for economic assistance), Medicaid (for medical care). In addition to providing direct aid to eligible frail or ill elderly persons, these services offer indirect aid to many caregiving families. The following points highlight a few interventions that directly assist the caregiver:

- **Respite intervention can include in-home or out-of-home care, formal or informal services** (friends/other relatives, or professional involvement). Respite is by definition **short-term—a few hours, a weekend, a week**. Such assistance can include **day care centers** as well as specific respite programs (**ranging from a respite worker coming into one's home to care for an elderly person to a temporary placement of the older person in an institutional setting**).
- **Hospice care is designed to aid, support, and train family members caring for a terminally ill patient.** The intervention specifically deals with the last 6 months of the patient's life. Family caregivers often continue their association with a hospice on either a formal (officially working with other families) or informal basis.
- **Day hospitals** offer a more structured respite/medical service and can help working families continue their caregiving functions by assuming responsibility for the elderly patients in need of medical attention, supervision, etc., during the working hours of the primary caregivers.

Such community resources should be considered to support or to replace family caregiving, when family burden is excessive, when family members are not appropriately motivated, and, of course, when family members are unavailable (or there are no family members).

Summary

Family care has been, and continues to be, the backbone of care to the elderly. Although caregivers are most often the women in the family, men are beginning to assume some of the responsibility. As discussed in this lesson, caregivers do any and all tasks necessary to maintain the frail or ill older family member in the community, avoiding institutionalization, often at great expense and sacrifice.

The motivations for family care can be positive or negative and includes personal/familial expectations often derived from cultural or religious teachings. Although most family members desire to care for their older relatives, **problems do occur in terms of who cares, where, how, and at what cost. The cost is exacted in terms of economics, personal health, relationships, privacy, employment, and disruption of family order.** The consequences of family caregiving involve not only the caregiver, but also the care recipient, as in cases of ineffective, inadequate care—or even abuse.

Proper intervention by the formal system of care can aid the care-giving family. With appropriate assessments, effective strategies can be implemented. Such strategies include support groups, education, clinical interventions (including case management) and the use of concrete community resources. Such interventions often require highly skilled professionals (physicians, psychologists, social workers, physical therapists, occupational therapists), but can, at times, use paraprofessionals and family members quite effectively.

REFERENCES

Allan, G. (1988). Kinship, responsibility, and care for elderly people. *Aging and Society, 8*(part 3), 249–268.

American Association of Retired Persons and The Traveler Companies Foundation (1988). *National survey of caregivers: Summary of findings*. Washington, DC: American Association of Retired Persons.

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.

Batson, C. D., & Coke, J. S. (1983). Empathic motivation of helping behavior. In J. R. Capcioppo & R. E. Petty (Eds.), *Social psychology: A sourcebook*. New York: Guilford Press.

Berkowitz, L. (1972). Social norms, feelings, and other factors effecting helping and altruism. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 6). New York: Academic Press.

Biegel, D. E., Sales, E., & Schulz, R. (1991). *Family caregiving in chronic illness*. Newbury Park, CA: Sage Publications.

Brody, E. M. (1981). Women in the middle and family help to older people. *Gerontologist, 21*, 471–480.

Brody, E. M. (1985). Parent care as normative family stress. *Gerontologist, 25*, 19–29.

Brody, E. M. (1990). *Women in the middle: Their parent-care years*. New York: Springer.

Brody, E. M., Litvin, S. J., Hoffman, C., & Kleban, M. H. (1992). Differential effects of daughters' mental status on their parent care experiences. *Gerontologist, 32*, 58–67.

Brubaker, T. H., & Brubaker, E. (1989). Toward a theory of family caregiving: Dependencies, responsibility, and use of service. In J. A. Mancini (Ed.), *Aging parents and adult children* (pp. 245–257). Lexington, MA: Lexington Books.

Brubaker, T. H., & Brubaker, E. (1992). Family care of the elderly in the US: An issue of gender differences. In J. I. Kosberg (Ed.), *Family care of the elderly: Social and cultural changes* (pp. 210–231). Newbury Park, CA: Sage Publications.

Cantor, M. H. (1983). Strain among caregivers: A study of experiences in the United States. *Gerontologist*, 23, 597–604.

Cicirelli, V. G. (1983). Adult children in attachment and helping behavior to elderly parents: A path model. *Journal of Marriage and the Family, 45*, 815–820.

Cicirelli, V. G. (1985). *Helping elderly parents*. Boston: Auburn House.

Colerick, E. J., & George, L. K. (1986). Predictors of institutionalization among caregivers of patients with Alzheimer's disease. *Journal of American Geriatric Society, 34*, 493–498.

Coulton, C. (1988). Perspective payment requires increased attention to quality of post-hospital care. *Social Work and Health Care, 13*, 19–31.

Duke University Center for the Study of Aging and Human Development (1978). *The Older American Resources and Services Methodology: Multidimensional Functional Assessment Questionnaire* (Vol. 2, pp. 169–170). Durham, NC: Author.

Fitting, M., Rabins, P., Lucas, M. J., & Eastham, J. (1986). Caregivers of dementia patients: A comparison of husbands and wives. *Gerontologist, 26*, 248–252.

Garbarino, J. (1947). The human ecology of child maltreatment: A conceptual model for research. *Journal of Marriage and the Family, 39*, 721–735.

Garcia, J. L., & Kosberg, J. I. (1992). Understanding anger: Implications for formal and informal caregivers. *Journal of Elder Abuse and Neglect, 4*, 87–99.

George, L. K., & Gwyther, L. P. (1986). Caregiver well-being: A multidimensional examination of family caregivers of demented adults. *Gerontologist, 26*, 253–259.

Hatfield, E., Walster, G. W., & Piliavin, J. A. (1978). Equity theory and helping relationships. In L. Wispe (Ed.), *Altruism, sympathy, and helping* (pp. 115–139). New York: Academic Press.

Hoffman, M. L. (1982). Development of prosocial motivation: Empathy and guilt. In N. Eisenberg (Ed.), *The development of prosocial behavior* (pp. 281–313). New York: Academic Press.

Hooyman, N. R., & Lustbader, W. (1986). *Taking care of your aging family members: A practical guide*. New York: The Free Press.

Horowitz, A. (1985). Family caregiving to the frail elderly. In M. P. Lawton & G. Maddox (Eds.), *Annual review of gerontology and geriatrics* (Vol. 5, pp. 194–246). New York: Springer.

Kosberg, J. I. (1988). Preventing elder abuse: Identification of high-risk factors prior to placement decisions. *Gerontologist, 28*, 43–50.

Kosberg, J. I., & Cairl, R. E. (1986). The cost of care index: A case management tool for screening informal care providers. *Gerontologist, 26*, 273–278.

Kosberg, J. I., & Cairl, R. E. (1991). Burden and competence in caregivers of Alzheimer's disease patients: Research and practice implications. *Journal of Gerontologic Social Work, 18*, 85–96.

Kosberg, J. I., & Dermody, E. W. (1985). *A follow-up study of discharged geriatric patients from a nursing home and rehabilitation center*. Unpublished paper presented at the annual meetings of the Southern Gerontological Society, Tampa, FL.

Kosberg, J. I., & Garcia, J. L. (1991). Social changes affecting family care of the elderly. *Bold [Journal of the International Institute on Aging (Malta)], 2*, 2–5.

Kosberg, J. I., Cairl, R. E., & Keller, D. M. (1990). Components of burden: Interventive implications. *Gerontologist, 30*, 236–242.

Lewis, J., & Meredith, B. (1988). Daughters caring for mothers. *Aging and Society, 8*, 1–21.

Litvin, S. J. (1992). Status transitions and future outlook as determinants of conflict: The caregiver's and care receiver's perspective. *Gerontologist, 32*, 68–75.

Lubkin, I. M. (1986). *Chronic illness: Impact and interventions*. Boston: Jones & Bartlett Publishers.

Mace, N. L., & Rabins, P. V. (1981). *The 36-hour day*. Baltimore: Johns Hopkins University Press.

Neal, M. B., Chapman, N. J., Ingersoll-Dayton, B., & Emlen, A. C. (1993). *Balancing work and caregiving for children, adults, and elders*. Newbury Park, CA: Sage Publications.

Noelker, L. S., & Townsend, A. L. (1987). Perceived caregiving effectiveness. In T. H. Brubaker (Ed.), *Aging, health and family: Long-term care* (pp. 58–79). Newbury Park, CA: Sage Publications.

Pfeiffer, E. (1975). A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. *Journal of the American Geriatric Society, 23*, 433–441.

Reis, H. T., & Gruzen, J. (1976). On mediating equity, equality, and self-interest: The role of self-presentation in social exchange. *Journal of Experimental Social Psychology, 12*, 487–503.

Shanas, E. (1979). The family as a social support system in old age. *Gerontologist, 6*, 169–174.

Stoller, E. P. (1983). Parental caregiving by adult children. *Journal of Marriage and the Family, 45*, 851–858.

Stone, R., Cafferata, G. L., & Sangl, J. (1987). Caregivers of the elderly: A national profile. *Gerontologist, 27*, 616–626.

Strauss, A. L., Corbin, J., Fagerhaugh, S., Glaser, B. G., Mainos, D., Suczek, B., & Weiner, C. L. (1984). *Chronic illness and the quality of life*. St. Louis: C. V. Mosby & Co.

Townsend, A. L., & Noelker, L. S. (1987). The impact of family relationships on caregiving effectiveness. In T. H. Brubaker (Ed.), *Aging, health and family: Long-term care* (pp. 80–99). Newbury Park, CA: Sage Publications.

Yesavage, J. A., & Brink, T. L. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research, 17*, 37–49.

Zarit, S. H. (1989). Issues and directions in family intervention research. In E. Light & B. Lebowitz (Eds.), *Alzheimer's disease, treatment, and family stress: Directions for research*. Washington, DC: U. S. Government Printing Office.

Zarit, S. H., & Zarit, J. M. (1982). Families under stress: Interventions for caregivers of senile dementia patients. *Psychotherapeutic Theory, Research & Practice, 19*, 461.

Zarit, S. H., Reever, K., & Peterson, J. (1980). Relatives of the impaired elderly: Correlates of feelings of burden. *Gerontologist, 20*, 649–655.

QUESTIONS BASED ON THIS LESSON

17. All of the following are current trends affecting family caregiving of the elderly *except*:

A. An increase in the death rates from stroke

B. A decrease in birth rates

C. An increase in life expectancy

D. An increase in the number of women pursuing careers outside the home

18. Interventions for family caregivers of elderly persons:

A. Do not vary in frequency, duration, and intensity

B. Should not be planned until assessment of the caregiving situation is completed

C. Are time-limited, in the case of peer-led support groups

D. Are designed to encourage burdened caregivers to place the care recipient into an institutional setting

19. Which of the following statements is true?

A. The formal service system of caregiving is the traditional method by which the needs of the elderly have been met.

B. Research has found that caregivers of the elderly are generally family members, especially divorced, middle-aged men.

C. Research has found that caregivers with higher income levels initially experienced greater stress, whereas those with lower income levels had long-term needs with fewer resources and greater stress later on.

D. The notion that discord can develop from generational value discrepancies between caregiver and care recipient is a myth.

20. Which of the following statements is false?

A. The Geriatric Depression Scale is a reliable and valid measure consisting of 30 questions.

B. According to recent research, middle- or upper-class whites are more likely to use support groups than members of a minority group.

C. Assessment is not a one-time event, because caregivers need updates on cognitive and physical levels of functioning of the care recipient.

D. Respite care is considered a long-term intervention that usually lasts at least 6 months.

DIRECTIONS IN MARRIAGE AND FAMILY THERAPY ©1994, The Hatherleigh Company, Ltd.
All rights reserved. Not to be reprinted without permission of the publisher.

Special Program Coordinators: Dennis A. Bagarozzi, PhD Frederic Flach, MD

Editorial Board of Consultants: James Alexander, PhD; Stephen Anderson, PhD; Judith I. Bagarozzi, MS; Insoo Kim Berg, MSSW; William J. Doherty, PhD; Craig Everett, PhD; Charles Figley, PhD; Alan S. Gurman, PhD; Harvey Joanning, PhD; Florence Kaslow, PhD; James F. Keller, PhD; Luciano L'Abate, PhD; Pieter le Roux, PhD; Howard Liddle, PhD; Mel Markowski, PhD; Fred P. Piercy, PhD; Lynda Dykes Talmadge, PhD

Managing Editor: Debra E. Cermele

Associate Editor: Steven L. Pessagno

Directions in Marriage and Family Therapy is a continuing education program published by The Hatherleigh Company, Ltd., 420 East 51 Street, New York NY 10022. For additional information, please call 800-367-2550 or 212-355-0882 (outside the US).

Directions in Marriage and Family Therapy

VOLUME 2 • LESSON 6

A Relational Approach to Low Sexual Desire

Lynda Dykes Talmadge, PhD, and William C. Talmadge, PhD

Dr. L. Talmadge is a clinical psychologist in private practice.

Dr. W. Talmadge is in private practice and an adjunct faculty member in the Department of Psychology at Georgia State University.

This lesson is adapted with permission from: Talmadge, L. D., & Talmadge, W. C. (1986) Relational sexuality: An understanding of low sexual desire. Journal of Sex & Marital Therapy, 12, 49-69.

VOL. 2, NO. 6

1994

KEY POINTS

- Sex therapy techniques have not devoted sufficient attention to the significance of the emotional relationship of the couple involved. For this reason, sex therapists often have been unable to help couples presenting with low sexual desire, because this problem is related to the health of the couple's emotional relationship.

- Each partner's sexuality is strongly influenced (directly and indirectly) by his or her family-of-origin, physical health, social context, and his or her partner's relationship to these factors.

- In general, nonsexual physical affection increases the likelihood of enjoyable sexual activity. Sexual activity is an act associated with feelings of vulnerability; marital intimacy is an extremely important factor in sexual satisfaction because intimacy increases emotional support and stability.

- The therapist should explore the relationship between both partners' intrapsychic issues and the couple's interpersonal issues. The sexual history of each partner should be taken individually so that each client becomes comfortable with the therapist while the therapist learns more about the individual.

- Marital dilemmas should be reframed so that *the relationship* is viewed as problematic; this way, neither partner is blamed. Problem sexual behavior is evaluated as adaptive.

- During sexual interaction, unconscious struggles of the early parent-child relationship are easily awakened. Thus, it is often helpful for therapists to explore such early conflicts in dealing with current problems involving low sexual desire.

- It is important for the therapist to uncover hostility that the partners might unconsciously feel for each other. Once this is done, the therapist must work with the couple to deal with this newly surfaced emotion rather than leave the couple to face it alone.

- The therapist should help the couple maintain a balance in the relationship with issues such as need and power. This balance sometimes helps a couple learn to express emotions appropriately if the therapist models the technique by disclosing his or her own personal feelings.

Introduction

Over the last several years, research has documented increasing reports of low sexual desire by both men and women (Frank, Anderson, & Rubinstein, 1978; Lief, 1977; LoPiccolo, 1980, 1982; Schover & LoPiccolo, 1982) **Low sexual desire results from a complex set of interacting physiologic, psychological, and cultural variables**, and is generally a matter of degree. At one end of the continuum are relatively mild problems with desire specific to a partner, a situation, or a type of sexual encounter. At the other end of the continuum is persistently and pervasively inhibited sexual desire, which, in its most severe presentation, is acted out as sexual aversion.

The Multiaxial Problem-Oriented Diagnostic System for Sexual Dysfunctions is a useful instrument for diagnosing low sexual desire (Schover, Friedman, Weiler, Heiman, & LoPiccolo, 1982). It establishes behavioral criteria along multiple dimensions; e.g., global/situational and duration. However, before sophisticated diagnostic systems are used, a clearer conceptualization of sexual desire should be attained. Zilbergeld and Ellison's delineation of the sexual response cycle (1980) includes five phases: interest, arousal, physiologic readiness, orgasm, and satisfaction. Kaplan's representation of the cycle (1979) includes desire, excitement, and orgasm. Thus, **interest or desire is conceptualized differently from arousal or excitement, both for diagnostic and treatment purposes.**

If desire is not arousal, then what is it? Levine (1984) proposes that **sexual desire results from an interaction of biologic drive, psychological motivation (willingness to behave sexually), and cognitive aspiration (a wish to behave sexually).** He believes that psychological motivation is the most critical factor clinically, and concludes that sexual desire is "the ability to integrate biologic, intrapsychic and interpersonal sexual complexity." LaPointe and Gillespie (1979) maintain that a biologic drive is present in everyone, but it may be repressed or unexpressed because of learned factors.

HISTORICAL PERSPECTIVES:

Historically, **sex therapy has focused primarily on the behavioral and technical levels of treatment** (Annon, 1974; Barbach, 1975; Heiman, LoPiccolo, & LoPiccolo, 1976; LoPiccolo, 1978; McCarthy, Ryan, & Johnson, 1975; Zilbergeld, 1978). This focus has been quite useful in two ways. First, it has **openly confronted the taboo of addressing sexual problems directly** in American culture, thereby facilitating education and treatment in sexual matters. Second, it has **clarified and increased our knowledge of human sexuality**, especially in its behavioral and functional aspects.

In the years since sex research, education, and therapy were originally legitimized by the pioneering works of Masters and Johnson (1966, 1970) and other professionals in the field, new information about sexual physiology and functioning has continued to surface (Kaplan, 1983; Wager & Green, 1981). For example, Wagner's 1981 discovery of a new artery in the penis has changed the theory of erection and diagnostic procedures for erectile problems (Wagner, Willis, Bro-Rasmussen, & Nielsen, 1982). These are among the important contributions made by the discipline of sex therapy. However, it is incumbent upon any school of psychotherapy to acknowledge its limitations.

Since Kaplan (1977, 1979) first discussed the problem of low sexual desire, the desire phase of the response cycle has been increasingly investigated in terms of both etiology and treatment (LaPointe & Gillespie, 1979; McCarthy, 1984). However, **too little attention has been devoted to the marital system, especially its emotional relatedness, for both diagnostic and treatment purposes** (McCarthy, 1984; Messersmith, 1976). **Sex therapists**

are only beginning to draw from the experience of couple therapists. Kaplan (1979) has focused primarily upon intrapsychic factors, both in etiology and treatment. LoPiccolo (1980) has stressed the complexity of desire phase disorders and has offered useful assessment procedures for diagnosis. However, his emphasis is on sexual behaviors and attitudes. Others have also emphasized behaviors and attitudes, employing short-term behavioral and cognitive approaches in treatment (LaPointe & Gillespie, 1979; McCarthy, 1984). Although they report some degree of success with individuals and couples, their sample sizes were very small, and results must be considered accordingly.

Zilbergeld and Killmann (1984) state that the efficacy of sex therapists (or any other therapists) in treating low desire is debatable. Others are less generous in their appraisal, maintaining that sex therapy procedures have failed with complaints of low desire (LaPointe & Gillespie, 1979; Berg & Synder, 1981). Berg and Snyder (1981) state, "There has emerged a growing consensus that treatment of sexual dysfunctions using a short-term behaviorally oriented directive approach without carefully examining the role of marital conflict and other dimensions of the relationship is both incomplete and shortsighted."

Sex therapy techniques have a poor record of success in treating low sexual desire largely because of the insufficient attention paid to the emotional relationship of the persons involved (LaPointe & Gillespie, 1979; Cookerly & McClaren,1982) **and to psychodynamics**. Friedman (1982) maintains that **relationship factors such as fear, vulnerability, passive-aggressive styles, and intimacy problems are important instigators of low sexual desire.** Even sex researchers who primarily investigate physiologic phenomena related to arousal and sexual attitudes concur that "...further research is needed to determine the importance of emotional involvement and trust as facilitating conditions for good sexual adjustment" (Hoon, 1983). In her study of the behavioral and psychological components that are related to a woman's experience of sexual response and satisfaction, Hoon (1983) concludes that it would be "...useful to know the degree to which women value commitment and loving along a number of interpersonal dimensions in the context of erotic responsivity and satisfaction."

Although the purpose, duration, intensity, and quality of each relationship varies greatly, sexual expression remains primarily relational. **Human beings have strong needs to be connected to one another in mutual dependency.** This assumption derives from an ethologic tradition of research: Observations of the phylogenetically lower primates as well as human infants and children reveal strong evidence supporting the **social nature of humans** (Harlow, 1958; Bowlby, 1969, 1973). Berscheid and Peplau (1983) state, "**Relationships with others lie at the very core of human existence**. Humans are conceived within relationships, born into relationships and live their lives within relationships with others. Each individual's dependency on other people for the realization of life itself, for survival during one of the longest gestation periods in the animal kingdom, for food and shelter and aid and comfort throughout the life cycle—is a fundamental fact of the human condition."

* * *

We realize the importance of the physical state of each partner, overt sexual behavior, and the intrapsychic issues involved in low sexual desire (Borneman, 1983; Kaplan, 1983). However, this lesson is primarily concerned with relational aspects of the problem. **We will focus on the intrapsychic issues of the partners as they overlap with the interpersonal issues between them.**

We feel that the most useful way to look at the intersection of the intrapsychic and interpersonal realms is through the conceptualization of **object-relations theory** and **systems theory**. Our treatment approach originates in systems theory, and gestalt psychotherapy, and experiential psychotherapy. We are primarily interested in intimate relationships; therefore, we will focus solely on married couples presenting with the complaint of low sexual desire that are not physiological in nature.

Relational Sexuality

The sexual relationship is a vital part of the personality of the marriage. The sexual character developed by the relationship emerges from the partners' personalities, sexual values, and behavior as well as the affect that they share concerning sexual issues. **This sexual character develops as a result of the partners' interaction, the indirect and direct influence of their families-of-origin, their physical health, and their social context.** The following case example involves a couple who had developed no real sexual character in their relationship as a result of physical health problems and their emotional consequences.

> *Mr. and Mrs. A had rarely been sexually active for several years. Mr. A had a life-threatening disorder; however, he denied that this had any significant effect on himself or his relationship with his wife. Over time, through therapy, Mr. A began to sense his rage and loss due to the limitations on his ability to take part in activities such as cutting the grass or playing ball with his children. As Mr. A increased this awareness, his rage would manifest in explosive outbursts, sadness, and loss. As Mr. A was able to work through these feelings in his wife's presence and discuss them with her, their sexual expression increased and intensified.*

The sexuality of most couples runs the gamut from frustration to delight. **At no time in the life of the couple do they confront themselves and each other in a more vulnerable way than when they are engaged in pleasurable sexual relations. This primitive vulnerability is the core of the difficulties so many couples experience in their sexual and marital relating.** In a committed relationship, sexuality is a physical expression of primary emotional bonds and is best understood in the context of the relationships that govern it; i.e., the family-of-origin and marriage. **The experience of giving and receiving physical pleasure in the marriage is often an unconscious symbolic reawakening of early child-parent interactions** (Scharff, 1982).

> *For a homework assignment, a therapist instructed Mr. B to give Mrs. B a full body massage. During this experience Mrs. B broke out in hives and tearfully pleaded with her husband to stop. In their next interview, Mrs. B was asked to imagine herself engaged in the homework assignment with her husband. As she did this, she was instructed to be aware of any intense feelings, memories, or images that came to mind. Mrs. B began to have a memory of herself at age 4 or 5 watching her father holding the family dog in the air by its hind legs and spanking it. In subsequent weeks she began recalling other incidents of her father's brutality and abusiveness that she had suppressed. Mrs. B eventually told her mother about these memories and gently confronted her with an intuition that her father had been physically abusive to her mother. Her mother initially denied this, but finally confessed that her husband had been physically abusive on various occasions when Mrs. B was a small child.*
>
> *Mrs. B, through her homework experience and revelations about her mother's denial of her father's abuse connected her hives and extreme fear to her experience of vulnerability and lack of protection. She was able to recognize that her frightened vulnerable child-self was being activated through the massage exercise.*

Each partner has an enormous effect on the other's experience and expression of his or her own sexuality.

Spouses' character structures and internalizations of the family-of-origin as well as the social context shape the emerging sexuality of the couple. Research indicates that **when the disinterested partner's sexual desire increases, the spouse may sometimes develop a sexual symptom** (LaPointe & Gillespie, 1979; Marshall & Neill, 1977). If we think of the marriage as a system, we can think of both partners as sharing the problem rather than the low sexual desire simply being a "symptom" exhibited by one of the partners. As the therapeutic work progresses, deeper levels of meaning and involvement in the problem are revealed, and the other partner may even manifest a sexual symptom. This process is an indicator of partners influencing one another as part of their bond. A more positive manifestation of a partner's influence can be seen in couples when the husband becomes more intimate and emotionally expressive with his wife and the wife's sexual desire increases (Framo, 1970; Haley, 1978; Jackson, 1957; Watzlawick, Weakland, & Fisch, 1974). The therapist should educate the couple about this process.

The ability to be affectionate can be a healing force in the sexual and personal relating between the partners. **If there is open expression of nonsexual physical affection, there is likely to be heightened sexual excitement, interest, and pleasure.** Affectionate touching is a special force that can reawaken old body sensations from the experience of early child-parent bonding (Bowlby, 1969; Harlow, 1962; Hollander, Luborsky, & Harvey, 1970; Montagu, 1978; Wallace, 1981). This contact of skin between husband and wife is a means of conscious and unconscious emotional feeding that can reach the innermost parts of the self. Physical affection between two marital partners has a positive association in sexual desire and expression (Wallace, 1981).

A final aspect of relational sexuality is the ability of the pair to move from parent-child interactions with each other (wherein one is more dependent and the other is the caretaker) to peer relating. **It is an enormous asset for any couple if they can move smoothly between these hierarchical and mutual stances with each other.** If a couple is stuck in a relationship where the roles are rigidly defined so that one is consistently the parent and the other is the child, there may be difficulties with sexual desire because of the unconscious influence of incest conflicts. Indeed, **it is difficult to relate sexually with a partner who is persistently parental or childlike**.

Intimacy in Marriage

Problems of low sexual desire are often indicative of difficulty with marital intimacy. The lack of connection within the relationship supports the lack of sexual contact interest and excitement. At this level, the sexual desire problem can be thought of as acting-out behavior of the lack of intimacy between the two.

The emotional connection of a couple is based upon the partners' ability to be intimate with each other. **As the couple becomes more intimate, their sexual satisfaction, desire, and activity increase.** "Intimacy" is derived from the Latin *intimare*, which means "to put, bring, drive, announce, or make known"; this is derived from *intimus*, the superlative of *intus*, which means "within." The contemporary definition of intimacy is **to make known the innermost parts of the self**. Trust, interdependence, vulnerability, power, mutuality, and the knowing and seeking of self are implied in this understanding of intimacy. L'Abate (1977) refers to intimacy as the **capacity and willingness to share hurt feelings**. Douvan (1977) asserts two elements essential to intimacy: the capacity and willingness to be **dependent** and "the **ability to bear, accept, absorb, and resolve interpersonal conflict and hostility**." Waring, McElrath, Lefcoe, and Weisz (1981) describe intimacy as being composed of **affection, expressiveness, compatibility, cohesion, sexu-**

ality, conflict resolution, autonomy, and identity. Intimacy within marriage requires ego strength, power, vulnerability, interdependency, trust, mutuality, and the knowing and seeking of self. Shepard (1979) maintains that "...what is revealed and shared is that which is deeply personal, basic, most important, experienced almost as the core of being or soul, that which may often have had to be defended from others and even hidden from oneself. To risk closeness with one another is to risk remembering old pain from violations of trust and oneness in early development, and evoke the early non-verbal conditionings that do not respond easily to cognitive formulas."

Marriage in American culture is the ultimate attempt to address the primary need for closeness. Parent-child and marital relationships are the two most intense examples of the social-emotional-physical interdependence of human beings. **Marital success requires tolerance for regression in the partners**, who must allow their childlike (needy) selves to emerge in mutual dependence (Dicks, 1967). Object-relations theorists speak about marital intimacy in a particularly compelling fashion, taking into account interaction of the intrapsychic with the interpersonal (Dicks, 1967; Framo, 1965; Friedman, 1980). Accordingly, they acknowledge the public and reality-oriented aspects of marriage but consider them less important than the unconscious connection between the partners.

Intimacy in marriage is especially difficult to achieve because it requires "an established sense of personal identity and ego-strength with a preservation of the capacity for dependence" (Dicks, 1967). **These attributes are often at odds within the person, the relationship, and the culture, producing conflict and confusion about when to depend and when to be self-sufficient.** A person might fear that in being too independent, one will lose one's connection with the beloved, and in being too dependent, one will lose oneself. **A paradox in relating is that we cannot be intimate while completely merged—a true intimacy requires some separation, some delineation of the individuals.** Thus, marriage is the arena in which the maturity of the personality is most fully challenged, for only the emotionally mature can negotiate closeness without merger.

This ambivalence in achieving marital intimacy is illustrated aptly by our historical and cultural contexts for close relationships. Gadlin (1977) traces the history of intimacy in the United States with considerable insight. Intimacy in Colonial times largely consisted of physical proximity. Personal life was not private, nor was it separated from public institutions; marriage was to serve the community, not the individual. As society developed, the industrial revolution tended to dehumanize the public sphere to such an extent that a need to compensate in private life emerged. The family decreased in socioeconomic importance and increased in psychological significance. Thus, **we find ourselves at the opposite end of the continuum from Colonial times, with our increased expectation of personal fulfillment in marriage.**

In our culture, an **emphasis is placed on self-sufficiency**; furthermore, there is an **implicit assumption that marriage should be an emotionally intimate, personally fulfilling relationship**. Achieving this is difficult for several reasons. Americans eschew spreading their dependent needs to the extended family and value confining them to the nuclear family (Hsu, 1981). With the emphasis on the individual's self-sufficiency, it is expected that the resources and abilities for making effective emotional commitments should be contained within the person. The extended kinship network is not acceptable as a resource in these processes. **The spouse and few children of the modern nuclear family are now the primary, if not exclusive, targets of our intense human needs. With this great burden falling on a few shoulders, it is not surprising that we disappoint one another.**

Marriage is an organic *process* rather than a product (Barnett, 1981). In the very beginning of this process, it often becomes apparent that partners are ill prepared for living in a committed, intimate relationship with a peer. They often have a deficit of successful experience with intimate relations with peers, perhaps because the main experiences they have accrued have been in intimate relationships when they are children—a time when their parents take care of them. As children, we are usually not required to be overly sensitive or even aware of the needs of other persons.

When most people begin intimate peer relationships, they negotiate this transition from the "child" position in the intimacy to that of the peer. **In the beginning of intimate relationships, each partner tends to regress to an infantile fantasy in which the other spouse is viewed as the omnipresent caretaker.** Each partner seems to assume that the other exists only for him or her, with the sole purpose in life of attending to his or her needs. Partners may resolve this transferential component to their relationship as they develop together. However, they may also regress to the transference and fantasy perceptions from former intimate relationships when they are under individual or relational stress.

Eventually, confronted with the reality of the partner and the situation, the marriage falls into disillusionment (Warkentin & Whitaker, 1966). It is at this point that many couples enter divorce proceedings, preferring to give up their partners rather than relinquish their fantasies. If, however, the partners do successfully negotiate this difficult stage, the potential exists for a deeper commitment and experience based on a shared construction of reality (Berger & Kellner, 1964; Sloan & L'Abate, 1985). From this perspective, intimacy is possible as the partners learn to be separate, yet close.

Through this process, marriage may serve a curative function for the persons involved (Wile, 1981). **Sociologists have long noted that one of the functions of marriage is to stabilize and support the adult personalities of the partners** (Parson & Bales, 1955). Dicks (1967) maintains that we unconsciously choose our partners for their curative potential. The fact that old wounds can be healed and scars repaired is supported by both clinical experience and Harlow's research with socially deprived monkeys. He found that the deprived monkey at the birth of her second offspring bonded somewhat better with that offspring due to the efforts of the first offspring to make contact with her (Harlow, 1962; Harlow & Zimmerman, 1959). **This assumption that interpersonal relationships can be restoring, as well as damaging, is an underlying premise for all psychotherapeutic work. The marriage can perform a similar role, supporting the adult personality and fostering its growth by the working through of unfinished interpersonal issues with the partner.**

In order to manage the ambivalence inherent in intimacy, partners often deny negative feelings about each other that can potentially threaten their connection. The partners may idealize one another, and, in doing so, may assume they must be everything to each other, correct all defects, and offer perfect gratification of all needs (Dicks, 1967). If the partner lives up to such perfection, the spouse is both gratified and threatened by that excellence. If the partner does not live up to it, the spouse is both relieved and disappointed by the partner's limitations. Again, ambivalence is pervasive.

Idealization requires exclusion of negative feelings from the relationship, the end result of which is an exclusion of all affect. Gradually, they turn down the intensity of the feeling between them so that an experience of numbness arises. They create a smooth relationship at the expense of their intensity and passion (Dicks, 1967; Kernberg, 1979). **Negative feelings must not be eliminated in intimate relationships; instead, they must be**

incorporated in such a way that leads to a resolution, not an escalation, of issues (Braiker & Kelley, 1979; Gurman, 1978; Rausch, Barry, Hertel, & Swain, 1974; Wile, 1981).

A great deal of energy is required to keep all of this intensity under control. The expenditure of such energy can drain the life from the marriage. Many couples, however, are able to maintain the smooth facade at the expense of intimacy for the maintenance of their lives together. **This bound-up energy also may result in physical, emotional, or psychosomatic symptoms in the partners or in their children** (Waring, 1980; Waring et al., 1981).

Couples who present with sexual desire problems often have an exaggerated form of this difficulty. They usually will present to the therapist by saying, "Everything is fine in the marriage except the sex. I just don't understand it. We never fight. We love each other. She [or he] just doesn't like sex." Things are smooth between them, but there is very little intimate connection and passionate involvement. The couple simply has no means for incorporating intense feelings into their relationship. The results are a blunting of feeling and expression and heightened anxiety in the relationship, all of which can lead to emotional distancing as a coping mechanism.

Obtaining a History from Both Partners

The process of history taking may be more valuable than the content obtained in taking the history. The therapist forms an impression of how the client relates to sexuality in general, takes the opportunity to teach and give permission, and ascertains important emotional issues for the client. Our general format involves an interview with the couple followed by one individual interview with each partner. Provided that sufficient information is obtained, the fourth interview is for feedback, at which time the relevant issues for each individual and how these may relate to their coupling are discussed along with the marital relationship issues.

> *During Mrs. C's individual interview of the history taking, she was asked about her first intercourse experience. She explained that she had not had intercourse until age 25. At that point in her life she decided, "I needed to get that behind me." She purchased a book on female sexuality and began to teach herself nonorgasmic masturbation for a 5-week period prior to having intercourse with her current boyfriend. She explained that she did this in much the same way as one would when trying to get in shape by doing sit-ups.*
>
> *From this question came a discussion about Mrs. C's sheltered and inexperienced sexual life and her fears and guilt related to masturbation. In this short interaction, the therapist was able to see that this woman approached her sexual life in a controlled manner in order to suppress her fears. Through this discussion of her first intercourse experience, the therapist was able to relate to Mrs. C with concern in a gentle and technical style that allowed her to explore the fear of her sexuality in the controlled presence of an expert on sex.*
>
> *In subsequent interviews, Mrs. C sought more information related to specific aspects of her sexuality, such as lubrication, intercourse during masturbation, and orgasms, while continuing to explore her fear and desire.*

Another important function of the history taking is to establish a productive therapeutic alliance early on. During this time, the therapist often can ascertain the couple's basic style of interaction as well as the various associated impasses. **In this phase of therapy, the therapist establishes himself or herself as a sexual expert with whom one is comfortable and free to discuss sexual issues.**

> *In a history-taking interview with Mr. and Mrs. D, who had been married 22 years, they presented the problem that Mrs. D. "doesn't like*

sex." Mr. D repeatedly answered questions the therapist addressed to Mrs. D. The therapist pointed this out to the couple with the suggestion that Mrs. D would probably like sex more if Mr. D respected her more, protected her less, and enabled her to speak for herself.

The sexual history taking is usually completed in a separate interview with each partner. This procedure assumes that if a couple is already experiencing tension and difficulty in sexual relating, the partners may find it very threatening to discuss sexual questions, issues, and history openly in front of each other early in the therapeutic process. It is also a time when the power of sexual secrets can be diffused. **If a revealed secret can be normalized by the therapist and accepted in an open way, its potential deleterious effect can be neutralized.**

"Three Patients"

Three patients are involved in the therapy: the two individuals and the marriage (Warkentin & Whitaker, 1966). **In the structure of the therapy, all three need attention.** Thus, spouses are worked with individually as well as in couple interviews. Some marital and family therapists disagree with this approach because secrets are unveiled during the individual interviews. These are dealt with in a similar vein to that mentioned above during the history taking discussion. **The individual focus is particularly useful in helping the person take charge of himself or herself in the interdependence, thereby interrupting the blaming of the partner for one's unfulfilled sexual needs.** It broadens the Masters and Johnson (1976) focus on the couple to include the individuals as well. Kaplan (1983) supports this approach, stating, "Most frequently both factors play a role and the therapist must be prepared to shift the therapeutic emphasis as resistances arise, sometimes confronting the partners with their destructive interactions and at other times working with the intrinsic anxieties of one or the other." Furthermore, **including work with the individual in the context of the marriage is a way to recognize and support that person's ability to be separate as well as his or her ability to make contact. Both are required if a genuine intimacy is to be established.**

Reframing

The overt sexual behavior of the symptomatic partner within the couple is deemphasized and presented as adaptive. Emphasis is placed upon how the relationship supports the sexual problem, which is defined as relational, and examples are given of how both partners participate in the difficulty presented. **This no-fault approach in the sexual life of the couple is especially important because one partner usually carries the low sexual desire symptom for the relationship.**

Mr. and Mrs. E, married 9 years, presented with the complaint that Mrs. E was experiencing low sexual desire and Mr. E was sexually eager. The couple had had no sexual intercourse for 15 months prior to therapy. Mr. E was told that his lack of pursuit of his wife in the emotional and sexual arena encouraged and supported her lack of desire. Later during therapy, this dynamic was reiterated when an incident was described in which they were beginning the initial phases of foreplay and the husband fell asleep. At this point the therapist not only emphasized the husband's participation in the problem and possibly his own lack of passion, but a paradoxical intervention was given as well. The therapist suggested that the couple was seriously and wisely considering all the repercussions that would take place in their marriage if they were to become consistently sexually active with one another. They were told to slow down their changing. Thus, the husband's falling asleep was interpreted in a positive and protective way as being one of wisdom and caution about upsetting the current balance of the relationship.

Regression

In our view of marriage, which is consistent with object-relations theory, each spouse seeks closure on some unfinished business or unmet needs that were not taken care of in the family-of-origin. Within this context, each partner is encouraged to "reparent" their spouse. **Each is told that he or she should view a part of the marital partner as a child who requires care. This approach helps in reworking early parent-child interactions that currently may be troublesome to the person.** Consider the case of Mr. and Mrs. F:

> *Mr. F was told by the therapist that his wife was a needy little girl who should be told constantly how wonderful she was and how important she was to him. Thus, the husband was addressing some narcissistic needs that his wife was unable to have fulfilled in her original family. Mrs. F was told that her husband was also a needy little boy and wanted her constant attention and involvement. Both were encouraged to respond to each other in these positions as much as possible. They were forewarned that there would be times when both partners simultaneously would feel needy and would be unable to address the needs of the spouse. At such times, they were encouraged to comfort one another as best they could and not to assume any major tasks. One suggestion for comfort when their neediness collided was to simply lie together and hold one another.*

Extreme Hostility

Couples who have been experiencing a sexual desire problem usually have been facing the problem over a substantial period of time. They have tried to blunt all feeling in order to contain their hostility with each other. **When the hostility is uncovered during the course of therapy, it is important not to leave the couple alone to face this newly surfaced emotion. Once the feelings are openly acknowledged and expressed between the two, the therapist can begin to move them through their anger into deeper understanding of each other. This process is facilitated by reframing the anger as the result of a deep hurt, an unmet need, fear, and/or anxiety.** This reframing often helps each individual to own the underlying reasons for anger with the partner and allows them to move through the anger into a more productive stage.

> *Mr. and Mrs. G had been married 3 years; both had been previously married. Mrs. G was extremely belligerent in relating to her passive husband. This degree of intense anger was seriously damaging any hope for the couple. During one of Mrs. G's tirades at Mr. G, the therapist waited until she had finished, and after a few moments of silence reached out and touched Mrs. G and said, "There surely is a hurt little girl inside you pleading for help." This led to Mrs. G weeping while talking about her father who abandoned her family-of-origin when she was 3 years old. Henceforth, when Mrs. G became enraged with her husband, Mr. G was instructed to ask, "What does that little girl want?" This continued to deflate Mrs. G's rage and address her hurt and need.*

Balancing the Relationship

According to systems theory, it is common in a marriage for one partner to exhibit most of the need, express most of the affect, provide most of the support, or display most of the power. **When a couple becomes imbalanced in these areas, they fail to give each other perspective, and the relationship no longer has a self-correcting mechanism.** Collusion is the result. **The therapist needs to help the couple identify imbalances and understand their implications.** For example, when a husband expresses most of the anger in the marriage, the therapist might suggest to the wife that she switch roles

with her husband and take her turn at carrying the anger. Because it is unlikely that she will be able to do so on command, a good way to begin is to have the wife role play her husband's feelings. This may lead her to a genuine realization of her own anger within the relationship.

Another means of dealing with the imbalance is to exaggerate it. For example, if the wife expresses most of the neediness within the relationship, she is encouraged to become more and more needy with her husband. Eventually the two cannot carry out the charade, and the gross exaggeration may lead to his discovering his own need and to her discovering her strength.

> *Mr. and Mrs. H had been married for 14 years. During that period, they had three children, Mr. H became very successful in his career, and Mrs. H became increasingly anxious. Mrs. H dealt with her husband's pursuit of his career ambitions by becoming deeply involved with her children and community. She expressed the anxiety, depression, and unhappiness of the couple in their interviews, as Mr. H sat quietly. At the next interview, Mrs. H was instructed to stop talking to her husband except for those occasions when it was necessary for the functioning of their lives. In addition, the couple was told they were to come to all future interviews in the same car, eat lunch together after the interview, and to take a 15-minute walk every evening. Mrs. H again was cautioned about speaking. In subsequent interviews, with much reinforcement to Mrs. H's silence, Mr. H began to express his feelings of sadness about his marriage and family. The affect in their marriage gradually was redistributed.*

Affection and Touching

Sex therapists have emphasized the importance of touch through their use of sensate focus (exercises for nongenital touching) (Masters & Johnson, 1976). **Many couples who seek therapy for a sexual desire problem have completely stopped touching each other and expressing affection because of the pain it reawakens in each of them.** Often, their only contact is verbal. **At this point, we try to decrease the verbiage in the marriage and replace it with more physical contact.** One way of doing this is to have the partners physically act out a communication to each other rather than to express it in words.

> *In a couples interview, Mr. I was feeling particularly saddened by a recent sexual encounter with his wife. He attempted to express his sadness physically to her through his touch. As he spoke of this encounter, tears came to his eyes and he was instructed to wipe his tears from his cheek and place them on his wife's cheeks. This expression was far more potent between the couple than if he had simply said, "I am feeling sad."*

Another way of providing the couple with more affection and touching while they are still trying to work on sexual issues is simply to tell them that they need to spend time holding each other. This should not be a sexual experience, nor should they speak to each other. They should merely find a quiet time and place where they are both comfortable with holding. **This kind of physical contact can replenish the emotional system of the partners.**

Experiential Interaction and Modeling

The interaction between the couple and the therapist within an experiential psychotherapeutic framework becomes an agent of change. **One way the therapist can teach the couple about emotional intimacy is by sharing his or her own feelings with them.** The therapist thus offers a model of disclosing and assists them in becoming more intimate with each other. Within the therapeutic

relationship, then, the therapist demonstrates basic parental qualities with the couple, such as setting limits, nurturing, and offering protection, affection, support, and guidance. Through the modeling involved in these interactions, the spouses are taught to perform these functions for each other.

Mr. and Mrs. J had been having sexual activity with each other about three times a year over the last 4 years. They had become increasingly alienated. Mr. J was stubbornly passive about his wife's ideas, plans, and desires; Mrs. J's resentment, anger, and hurt was exacerbated as a consequence. These feelings became most pronounced in major decision-making processes; as a result, the partners had a difficult time working as a team. Mr. J had been school phobic in his pubescent years and had dealt with his mother's demands by total withdrawal or symbiotic attachment. Mrs. J's father was a "brilliant and gifted professional" who never followed through or finished professional or personal matters. Mrs. J viewed her father as a promise breaker and felt particularly vulnerable to her mother when her father went away on business trips. Her mother was an unpredictable, sullen woman who would sometimes go many days without speaking to family members.

In one interview, Mr. and Mrs. J discussed an argument they were having over the sale of their house. They had been offered a reasonable contract, but Mr. J was passively resisting, and Mrs. J was becoming furious and panicked. She was certain that her husband was not going to respond to the contract offer and they would be unable to move to the house of their dreams, for which they had signed a contingent contract. Mrs. J was pouring her rage and fear onto him. She stated, "You haven't done a damned thing about the house all along, and here we have a good offer on the house and you want to negotiate over a few hundred dollars. You're going to let the whole damn thing fall in!" Mr. J withdrew.

At this point, the therapist intervened and drew Mrs. J's fire. The therapist told her, "I feel overwhelmed by your fear, rage, and hurt. It's hard to respond.... [Mrs. J starts interrupting] Please listen to me, I'm trying to give you something. It's hard to get a word in edgewise with you, much less respond to your need....[Mrs. J interrupts again, to which the therapist firmly replies...] Hush! I'm trying to give you something. I know you're terribly frightened and panicked that your husband isn't going to act on this deal—just like your father failed you." [Mrs. J begins weeping.]

Then, the therapist suggests that Mr. J tell his wife his thoughts about the deal and the alternatives he foresees. The therapist further instructs Mr. J to not let his wife overwhelm him with her interruptions. Through these brief interactions, Mr. J observed how another person (the therapist) was responding to his wife's need and fear by neither withdrawing nor becoming symbiotically attached, which in this case would have been to capitulate to her every demand. Mrs. J became less frightened because she had a therapist who would not fail her by abandoning her in distress.

Conclusion

The treatment of married couples with low sexual desire is a complex process. Our focus has been solely on the relationship of the couple. We contend that a certain relationship quality must be maintained in order for the couple to have a satisfactory sex life. **Some components of this quality include intimacy, self-responsibility, power, affection, and communication with limited projections. The intended effects of the therapy are to have both persons claim responsibility for their own needs and for negotiating them satisfactorily with the spouse, increase their emotional capacities, enable them to perform nurturing functions for each other, and to reacquaint the partners with their sexual and personal passions.**

REFERENCES

Annon, J. (1974). *The behavioral treatment of sexual problems* (Vol.12). Honolulu: Enabling Systems.

Barbach, L. G. (1975). *For yourself: The fulfillment of female sexuality*. New York: New American Library.

Barnett, J. E. (1981). The natural history of a marriage. *Pilgrimmage*, 9, 5–19.

Berger, P., & Kellner, H. (1964). Marriage and the construction of reality. *Diogenes*, *46*, 1–24.

Berg, P., & Synder, D. K. (1981). Differential diagnosis of marital and sexual distress: A multidimensional approach. *Journal of Sex and Marital Therapy*, *7*, 290–295.

Berscheid, E., & Peplau, L. A. (1983). The emerging science of relationships. In H. H. Kelley, E. Berscheid, A. Christensen, J. H. Harvey, T. L. Huston, G. Levinger, E. McClintock, L. A. Peplau, & D. R. Peterson (Eds.), *Close relationships*. New York: W. H. Freeman.

Borneman, E. (1983). Progress in empirical research on children's sexuality. *SIECUS Report*, *12*, 1–5.

Bowlby, J. (1969). *Attachment and loss, I.* New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss, II.* New York: Basic Books.

Braiker, H. B., & Kelley, H. H. (1979). Conflict in the development of close relationships. In R. Burgess & T. Huston (Eds.), *Social exchange in developing relationships*. New York: Academic Press.

Cookerly, J. R., & McClaren, K. A. (1982). Sex therapy with and without love: An empirical investigation. *Journal of Sex Education & Therapy*, *8*, 35–38.

Dicks, H.V. (1967). *Marital tensions*. New York: Basic Books.

Douvan, E. (1977). Interpersonal relationships: Some questions and observations. In G. Levinger & H. Raush (Eds.), *Close relationships: Perspectives on the meaning of intimacy*. Amherst, MA: University of Massachusetts Press.

Framo, J. L. (1965). Systematic research on family dynamics. In I. Boszormenyi-Nagy & J. Framo (Eds.), *Intensive family therapy: Theoretical and practical aspects*. New York: Harper & Row.

Framo, J. L. (1970). Symptoms from a family transactional viewpoint. In N. Ackerman (Ed.), *Family therapy in transition*. Boston: Little, Brown & Co.

Frank, E., Anderson, C., & Rubinstein D. (1978). Frequency of sexual dysfunction in "normal" couples. *New England Journal of Medicine*, *299*, 111–115.

Friedman, L. J. (1980). Integrating psychoanalytic object-relations understanding with family systems intervention in couples theory. In J. Pearce & L. Friedman (Eds.), *Family therapy: Combining psychodynamic and family systems approaches*. New York: Grune & Stratton.

Friedman, J. M. (1982). A treatment program for low sexual desire. Paper presented at the annual meeting of The Society for Sex Therapy and Research, Charleston, SC.

Gadlin, H. (1977). Private lives and public order: A critical view of intimate relationships in the United States. In G. Levinger & H. Rausch (Eds.), *Close relationships: Perspectives on the meaning of intimacy*. Amherst, MA: University of Massachusetts Press.

Gurman, A. S. (1978). Contemporary marital therapies: A critique and comparative analysis of psychoanalytic, behavioral, and systems theory approaches. In T. J. Paolino & B. S. McCrady (Eds.), *Marriage and marital therapy: Psychoanalytical, behavioral and systems theory perspectives*. New York: Brunner/Mazel.

Haley, J. (1978). Toward a theory of pathological systems. In P. Watzlawick & J. H. Weakland (Eds.), *The interactional view*. New York: Brunner/Mazel.

Harlow, H. F. (1958). The nature of love. *American Psychologist*, *13*, 673–685.

Harlow, H. F. (1962). Social deprivation in monkeys. *Scientific American*, *207*, 136.

Harlow, H. F., & Zimmerman, R. R. (1959). Affectional responses in infant monkeys. *Science*, *130*, 421–432.

Heiman, J., LoPiccolo, L., & LoPiccolo, J. (1976). *Becoming orgasmic: A sexual growth program for women*. Englewood Cliffs, NJ: Prentice-Hall.

Hollender, M. H., Luborsky, L., & Harvey, R. B. (1970). Correlates of the desire to be held in women. *Journal of Psychosomatic Research*, *14*, 387–390.

Hoon, P. (1983). A path analysis model of psychosexuality in young women. *Journal of Research in Personality*, *17*, 143–152.

Hsu, F. L. K. (1981). *Americans and Chinese: Passages to differences* (3rd ed.). Honolulu: University Press of Hawaii.

Jackson, D. D. (1957). The question of family homeostasis. *Psychiatric Quarterly Supplement*, *31*, 69–70.

Kaplan, H. S. (1977). Hypoactive sexual desire. *Journal of Sex and Marital Therapy*, *2*, 3–9.

Kaplan, H. S. (1979). *Disorders of sexual desire: And other new concepts and techniques in sex therapy*. New York: Brunner/Mazel.

Kaplan, H. S. (1983). *The evaluation of sexual disorders: Psychological and medical aspects*. New York: Brunner/Mazel.

Kernberg, O. (1979). *Object relations theory and clinical psychoanalysis*. New York: Jason Aronson.

L'Abate, L. (1977). Intimacy is sharing hurt feelings: A reply to David Mace. *Journal of Marriage and Family Counseling, 3*, 13–16.

LaPointe, C., & Gillespie, H. G. (1979). A short-term cognitive and behavioral treatment approach to sexual desire phase dysfunction. *Journal of Sex Education and Therapy, 1*, 35–38.

Levine, S. B. (1984). An essay on the nature of sexual desire. *Journal of Sex and Marital Therapy, 10*, 83–96.

Lief, H. I. (1977). Inhibited sexual desire. *Medical Aspects of Human Sexuality, 11*, 94–95.

LoPiccolo, J. (1978). Direct treatment of sexual dysfunction. In J. LoPiccolo & L. LoPiccolo (Eds.), *Handbook of sex therapy*. New York: Plenum Press.

LoPiccolo, J. (1982). Research and clinical innovations in sex therapy. Paper presented at the annual meeting of the Society of Sex Therapy and Research, Charleston, SC.

LoPiccolo, L. (1980). Low sexual desire. In S.R. Leiblum & L.A. Pervin (Eds.), *Principles and practice of sex therapy*. New York: Guilford Press.

Marshall, J. R., & Neill, J. (1977). The removal of a psychosomatic symptom: effects on the marriage. *Family Process, 16*, 273–280.

Masters, W. H., & Johnson, V. (1966). *The human sexual response*. Boston: Little, Brown & Co.

Masters, W. H., & Johnson, V. (1970). *Human sexual inadequacy*. Boston: Little, Brown & Co.

Masters, W. H., & Johnson, V. E. (1976). Principles of the new sex therapy. *American Journal of Psychiatry, 133*, 548–554.

McCarthy, B. W., Ryan, M., & Johnson, F. A. (1975). *Sexual awareness: A practical approach*. San Francisco:Boyd & Fraser.

McCarthy, B. W. (1984). Strategies and techniques for the treatment of inhibited sexual desire. *Journal of Sex and Marital Therapy, 10*, 97–104.

Messersmith, C. E. (1976). Sex therapy and the marital system. In D. Olson (Ed.), *Treating relationships*. Lake Mills, IA: Graphic.

Montagu, A. (1978). *Touching: The human significance of the skin* (2nd ed.). New York: Harper & Row.

Parson, T., & Bales, B. F. (1955). *Family socialization and interaction process*. Glencoe, IL: Free Press.

Rausch, H. L., Barry, W. A., Hertel, R. K., & Swain, M. A. (1974). *Communications, conflict and marriage*. San Francisco: Jossey-Bass.

Scharff, D. E. (1982). *The sexual relationship: An object relations view of sex and the family*. Boston: Routledge Kegan Paul.

Schover, L. R., & LoPiccolo, J. (1982). Treatment effectiveness for dysfunctions of sexual desire. *Journal of Sex and Marital Therapy*, 8, 179–197.

Schover, L. R., Friedman, J., Weiler, S. M., Heiman, J. R., & LoPiccolo, J. (1982). The multiaxial problem-oriented diagnostic systems for the sexual dysfunctions: An alternative to DSM-III. *Archives of General Psychiatry, 39*, 614–619.

Shepherd, I. L. (1979). Intimacy in psychotherapy. *Voices, 15*, 10.

Sloan, S., & L'Abate, L. (1985). Intimacy. In L. L'Abate (Ed.), *Handbook of family psychology and psychotherapy*. Homewood, IL: Dow Jones-Irwin.

Wallace, D. H. (1981). Affectional climate in the family of origin and the experience of subsequent sexual-affectional behaviors. *Journal of Sex and Marital Therapy, 7*, 296–306.

Wagner, G., & Green, R. (1981). *Impotence: Physiological, psychological and surgical diagnosis and treatment*. New York: Plenum Press.

Wagner, G., Willis, E.A., Bre-Rasmussen, F., & Nielsen, M.H. (1982). New theory on the mechanism of erection involving hitherto undescribed vessels. *Lancet*, 416–418.

Waring, È. M. (1980). Marital intimacy, psychosomatic symptoms and cognitive therapy. *Psychosomatics, 21*, 595–601.

Waring, E., McElrath, D., Mitchell, P., & Derry, M. (1981). Intimacy and emotional illness in the general population. *Canadian Journal of Psychiatry, 26*, 167–172.

Waring, E., McElrath, D., Lefcoe, D., & Weisz, G. (1981). Dimensions of intimacy in marriage. *Psychiatry, 44*, 169–175.

Waring, E. M., & Reddon, J.R. (1983). The measurement of intimacy in marriage: The Waring Intimacy Questionnaire. *Journal of Clinical Psychology, 39*, 53–57.

Warkentin, J., & Whitaker, C. (1966). Serial impasses in marriage. *Psychiatric Research Reports, 20*. Washington, D.C.: American Psychiatric Association.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. New York: Norton.

Wile, D. B. (1981). *Couples therapy: A nontraditional approach*. New York: Wiley.

Zilbergeld, B. (1978). *Male sexuality: A guide to sexual fulfillment*. Boston: Little, Brown.

Zilbergeld, B., & Ellison, C. R. (1980). Desire discrepancies and arousal problems in sex therapy. In S.R. Leiblum & L.A. Pervin (Eds.), *Principles and practice of sex therapy*. New York: Guilford Press.

Zilbergeld, B., & Killmann, P. R. (1984). The scope and effectiveness of sex therapy. *Psychotherapy, 21*, 319–326.

QUESTIONS BASED ON THIS LESSON

21. Which of the following is not suggested by the authors as an option for dealing with couples presenting with low sexual desire?

A. Balancing strong emotions between the partners

B. Obtaining a sexual history from each partner individually

C. Viewing each partner as a needy child

D. Bringing hostility to the surface and letting the couple face it themselves

22. According to the authors, sex therapy has not been as successful as it could be because:

A. There is an unwillingness in society to discuss sexual issues

B. The physical explanations for sexual problems have been extremely difficult to decipher

C. There has not been enough focus on the emotional relationship of the partners

D. The physical element of sex has not been emphasized enough

23. Which of the following is not mentioned by the authors as a feeling often associated with satisfactory sexual activity?

A. Self-responsibility

B. Intimacy

C. Affection

D. Envy

24. According to the authors, which of the following describes the correct relationship between nonsexual intimacy and sexual activity?

A. Increased nonsexual intimacy leads to increased sexual activity

B. Increased sexual activity leads to increased nonsexual intimacy

C. Increased nonsexual intimacy leads to decreased sexual activity

D. Increased sexual activity leads to decreased nonsexual intimacy

DIRECTIONS IN MARRIAGE AND FAMILY THERAPY
©1994, The Hatherleigh Company, Ltd.
All rights reserved. Not to be reprinted without permission of the publisher.

Special Program Coordinators: Dennis A. Bagarozzi, PhD Frederic Flach, MD

Editorial Board of Consultants: James Alexander, PhD; Stephen Anderson, PhD; Judith I. Bagarozzi, MS; Insoo Kim Berg, MSSW; William J. Doherty, PhD; Craig Everett, PhD; Charles Figley, PhD; Alan S. Gurman, PhD; Harvey Joanning, PhD; Florence Kaslow, PhD; James F. Keller, PhD; Luciano L'Abate, PhD; Pieter le Roux, PhD; Howard Liddle, PhD; Mel Markowski, PhD; Fred P. Piercy, PhD; Lynda Dykes Talmadge, PhD

Managing Editor: Debra E. Cermele

Associate Editor: Steven L. Pessagno

Directions in Marriage and Family Therapy is a continuing education program published by The Hatherleigh Company, Ltd., 420 East 51 Street, New York NY 10022. For additional information, please call 800-367-2550 or 212-355-0882 (outside the US).

Directions in Marriage and Family Therapy

SPECIAL REPORT

The Individualized Family Service Plan

Harvey Joanning, PhD, Alan Demmitt, MA, Mary Jane Brotherson, PhD, Susan McBride, PhD, and Dorris Whiddon, MS

Dr. Joanning is Professor and Coordinator and Mr. Demmitt and Ms. Whiddon are doctoral students in the Doctoral Specialization in Marriage and Family Therapy, Department of Human Development and Family Studies, Iowa State University, Ames, IA.

Dr. McBride is Associate Professor and Dr. Brotherson is Assistant Professor in the Specialization in Early Childhood Special Education, Department of Human Development and Family Studies, Iowa State University, Ames, IA.

VOLUME 2

1994

100

For many years, early intervention services for children with disabilities have focused on the child. **More recently, services have been based on the developing philosophy that the family, rather than the child with a disability, should be the focus of intervention.** In 1986, this concept led to the passage of Public Law 99-457, Part H, Individuals with Disabilities Education Act (IDEA). **IDEA provides the opportunity for the entire family to be involved in the early intervention services provided to infants and toddlers who are disabled or who have special health care needs. The mechanism required by IDEA to provide such services to families is the Individualized Family Service Plan (IFSP).** The IFSP is the cornerstone to building supportive family programs (Deal, Dunst, & Trivette, 1989; Turnbull, 1988).

The purpose of an IFSP is to create and implement a program to meet the unique needs and priorities of the family and their children. The IFSP must be developed by a multidisciplinary team and contain: a) a statement of the child's present levels of development; b) a statement of the family's strengths and needs relating to enhancing the child's development; c) a statement of major outcomes expected to be achieved for the child and family; d) the criteria, procedures, and timeliness for determining progress; e) the specific early intervention services necessary to meet the unique needs of the child and family including the method, frequency, and intensity of service; f) the projected date for the initiation of services and the expected duration; g) the name of the service coordinator; and h) procedures for transition from early intervention into the preschool program. **The belief that a team approach is necessary and that families are essential members of the team is a vital tenet of the law** (McGonigel & Garland, 1988). Family therapists are new members of this team. **The reauthorization of IDEA now includes marriage and family therapists as providers of service for families covered by the legislation** (Federal Register, May 1, 1992, Section 303.12).

Family therapists in private practice or involved in agency work may find involvement in the formulation and implementation of IFSPs to be an appropriate adjunct to traditional family therapy. The development of IFSPs and implementation of services occur in homes, schools, hospitals, community early childhood education programs, or the offices of participating professionals—wherever families choose and feel comfortable. Funding for services provided comes from state and federal sources as administered by the Department of Health and Human Services and the Department of Education. Family therapists can enter the IFSP process by contacting local and state agencies that are funded to provide services. Typically, these include local schools, hospitals, and related children's service agencies. Most family therapists already have contacts with these agencies and can become involved in the IFSP process by expressing an interest.

The IFSP process is still being established in most areas, so family therapists can often become involved in developing the service system. Although family therapists were specifically named in IDEA, their roles were not specified. Consequently, family therapists willing to become involved in establishing the IFSP process in their area can define their role as the system is developed. Our recommendation is that family therapists take this opportunity to define and develop a new role for themselves in the IFSP process.

The principles underlying the IFSP process include: a) **infants and toddlers are dependent on their family for care and survival—thus, a family-centered approach is best;** b) "family" should be defined in a way that reflects the diversity of families; c) the family's uniqueness, values, race, culture, and decision-making needs must be respected; d) for the IFSP to succeed, the family and professionals must work together; e) services should be flexible and responsive to the family's needs; and f) the best way to meet the diverse needs of families is to have agencies work together in the planning and implementation of the IFSP (Johnson, McGonigel, & Kaufmann, 1989).

The IFSP process can be thought of as three phases that overlap in an ongoing process: a) establishing rapport and assessment; b) developing the IFSP; and c) implementing the IFSP. Family therapists can be involved in each of these stages, although their role can vary considerably. Each stage will be described along with a discussion of how family therapists can be involved so that the spirit and letter of the law are met.

Initial Rapport Setting and Assessment

Ideally, assessment is the stage during which relevant professionals and family members evaluate the child about whom someone, usually a parent, has a concern. The concern can range from a suspected learning disability to a major handicap or life threatening medical condition. **The purpose of the assessment is to evaluate what the child's needs may be and arrange appropriate services for the child.** The assessment phase should also involve professionals and parents in evaluating the family's needs and establishing a mutually respectful supportive working relationship. **IFSPs are supposed to be "family centered" and thus place the family in charge rather than have the family merely follow the lead of professionals.**

Family therapists can play an important role during assessment by assisting in the identification of family needs and priorities as well as helping to support the family in guiding the IFSP process in order to meet their own needs. During assessment, various specialists (e.g., occupational therapists, nurses, school psychologists) work directly with the child to determine what, if any, disability is present. Ideally, the child and family work together with professionals in identifying the child's strengths and needs. These professionals are very experienced at assessing a child's level of functioning, but may be less experienced in assessing the family's needs, concerns, and priorities.

For most families, the assessment phase of the IFSP is a time when they are fully confronted with the seriousness of their child's condition. Facing the reality of long term physical or mental disability can be emotionally charged. **Involving a family therapist in the assessment phase can help the family to discuss and begin to deal with its emotional issues.** A family therapist can also assist other professionals to prepare the family members to be decision-makers during the IFSP process if they wish to take this role.

Throughout the IFSP process, families have a choice as to how much they want to be involved. Consequently, **families should be supported to be involved and taught how to be so, but they should not forced.** The discussion that follows assumes that the family chooses to be involved in the process.

Assessment interviews usually involve professionals interacting directly with the child while the mother observes and answers questions directed to her by professionals. A more family-centered alternative would be to have both parents or other significant family members included in the assessment interviews. Professionals would listen carefully to the family members' perceptions and concerns regarding the child's abilities. This alternative is very similar to an initial family therapy session.

One way to support parents' involvement in the assessment process is to have them start the assessment procedure. Professionals could ask the parents to, "show us what your child can do." Children are sometimes shy around professionals, especially if they are strangers. The mother and father are familiar with their child's abilities and can therefore describe what the child can and can not do while assisting the child to demonstrate his or her capabilities.

Even after the initial demonstration, parents can continue to be directly involved in their child's assessment. Rather than simply doing the assessment themselves, professionals can instruct the parents in how to do the

assessment while the professionals watch. Alternatively, parents and professionals can do the assessment together. This process increases the probability that the parents will see themselves as involved, and it can be used as a teaching method to prepare the parents to take the lead in any interventions that are implemented following assessment. **Because family therapists often interact with and teach families new skills during family therapy, they can assist other professionals in involving families in the assessment process.**

Involving fathers in the assessment process creates a context in which family-wide issues are more likely to be discussed. Family therapists have long known that leaving the father out of therapy often negates the effect of interventions designed to help families cope effectively. In similar fashion, having the father involved in the assessment process increases the chances that he will be involved in the child's care and will be supportive of the mother, who is usually more involved in direct caregiving. Involving the father also provides parents with an opportunity to talk directly with each other regarding their concerns about their child.

It is important that professionals conducting assessment interviews pay particular attention to what parents say about their child's abilities. Some children will not perform up to their capabilities in the presence of strangers. If the parents feel that the professionals doubt what they are saying because during the assessment procedure the child cannot function at the level parents report, the parents are likely to feel discouraged. **Having the parents involved in the assessment procedure increases the chances that the child will perform better, because the mother and father are familiar.** If the child does not perform as reported by parents, careful note should be made of what the parents have observed the child doing so as not to negate their comments. Professionals present during an assessment interview should monitor the parents' emotional state and support them while commenting about their child's capability. In short, **listening attentively encourages further parent disclosure, a phenomenon familiar in therapy and necessary to fully develop an IFSP.**

Many families who enter the IFSP process are glad to get any help offered. However, they have a right to make informed decisions about what services they receive. Many families assume that the professionals involved in the assessment process are in charge. This attitude is understandable, given that the family may not know how to deal with their child, may not understand the nature of their child's problem, and may feel uncomfortable taking a more active role in determining how their child's needs are met. Consequently, their role in the process may need to be explained several times over the first months professionals work with them. **Professionals may have to take the lead initially but should work to prepare the family to assume a leadership role. Professionals may have to take the role of family advocate—that is, work to ensure that the family is coping by supporting them during assessment, informing them of their rights, and educating them about how to be in charge of their IFSP.**

Family therapists involved in the assessment process can model how to support family functioning. An example question is, "Many of the families I've worked with have a hard time when they find out their child has a problem. I'm concerned about how your family is doing. Could you tell me how having your child become part of your home has affected your family?" If the family expresses concerns or questions that the professional is qualified to deal with, the next step is clear. If they bring up an issue or problem the professional can't handle, the family therapist can deal with the concern while the other professional(s) present observe or interact when appropriate. This may seem obvious, but many professionals are hesitant to ask personal questions and many families are hesitant to disclose such information.

To be able to reach out to a family, it is crucial that the professionals involved are respectful, tolerant, and non-judgmental. The professional's role is not to judge the family but to act as a sounding board. Family therapists involved in the IFSP process can model being an "active listener"—that is, a person who tries to understand what the family is saying and feeling. Paraphrasing what the family says without adding comments of their own allows the professionals involved to gather necessary information while leaving the family feeling understood and supported. **Family therapists can model and teach these skills when interacting with other professionals who work with families of children with disabilities.**

In addition to professionals working with a family, McBride et al. (1993) have shown that **it is helpful to many parents new to the IFSP to be able to contact other parents who are already well into the process.** Giving parents the names of experienced parents who are supportive and interested allows families the opportunity to "normalize" their experience.

Developing the IFSP

At some point during or following the assessment stage, a plan of action is formulated and formalized. **This action plan is a written document that outlines the child's strengths and needs. The plan also lays out goals for the child and the family, in addition to detailing services needed to reach those goals.** If the family has been actively involved in the assessment stage, this review of the IFSP will be a "sharing" rather than a "presentation" by professionals to the family. In some cases, the IFSP will be discussed informally over several meetings with the home teacher and/or other service providers. In other cases, a formal meeting will be held with family members and professionals present. There is no one way to formalize the IFSP process, because circumstances will vary from family to family. However, **every family should be given an opportunity to take an active role in its development.**

A process congruent with the intent of the law is to have family members, usually the parents, be formally involved in *writing* the plan, rather than simply acting as recipients of it. Involving parents in writing the plan makes them more involved and more likely to "own" the plan—that is, see it as their own rather than the professionals'. Along with the active parental involvement in assessment discussed earlier, having parents help write the IFSP will increase the chances that parents will take charge of the plan and be its leaders.

Family therapists can also be actively involved in helping the parents write the IFSP. **Just as therapists help families develop contracts or agreements during therapy sessions, therapists can work with other professionals to guide the family through the writing of a formal IFSP document.** Family therapists can also be involved in the meetings in which professionals and the family discuss the formal IFSP.

The IFSP is usually shared with the family during a meeting convened by professionals who discuss their assessment findings and make recommendations for the child's care and training during a meeting. **A family-centered alternative would be to have the family run the meeting assisted by a family therapist. Such a move would increase the probability that the family would be actively involved in the discussion and have their concerns and desires heard.**

Some families feel overwhelmed during a formal IFSP meeting which is attended by all the professionals who have assessed the child and family. **An alternative strategy is to have one or two professionals meet with the family informally to develop and write the IFSP.** Additional meetings with other professionals could be scheduled to complete the process.

Family members may have a different perception of

the IFSP process than professionals have. Consequently, it may be helpful for the family therapist involved to debrief the family regarding their perceptions. **Parents may need further explanations or emotional support.** Reviewing the family's experience of the process will increase the chances that its needs are being met, its members feel considered, and a good working relationship is established among professionals and family members involved in the IFSP.

Implementing the IFSP

The reason for developing the IFSP is to provide a family and its child with services which will promote the child's development and help the family cope effectively. Taking the steps outlined earlier should give service providers a better idea of the family's needs and promote the type of interpersonal relationship needed to work closely with the family.

Following the development of the formal IFSP, various services are delivered to the family. For example, a home teacher usually makes regular visits to assist the child directly and teach parents how to help their child develop optimally. A physical therapist, speech therapist, or other specialist may work directly with the child on a regular basis. However, in many cases the entire family has needs that may require the services of a family therapist.

Many of the families involved in the IFSP process feel strong emotions due to the realization that their child is disabled. These emotions include anxiety about their child's future; stress due to the demands of physically caring for their child; disappointment that their child will not be able to do what other children can; concern that they will not be able to meet the financial demands of providing for their childl; and distress over the impact of their child's disability on the parent's marriage, the development of other children in the family, and the general ability of the family to function.

If early intervention professionals are unable to provide a solution to a family's problem, or an issue is too complex to be dealt with by simply listening and being supportive, family therapy can be utilized. Because family therapists are specifically trained to work with complex family issues that evoke strong emotional responses, they should be included in the team of professionals providing services to families as part of their IFSP. In addition, family therapists work from a systems perspective, and are used to including all human systems that are in some way involved with the issue needing attention. In this case, the systems worked with would include at least the family, but could also involve early intervention professionals or other agency personnel who act as consultants to the family. **Because family therapists tend to include rather than exclude other professionals, involving families in therapy as part of the IFSP can facilitate and coordinate the overall process.**

In addition, **family therapists are always family-centered in their work.** Because of their theoretical orientation and training, family therapists automatically meet the spirit of Public Law 99-457 which requires IFSPs to be family-centered. Working with family therapists will provide support to early intervention professionals to be family-centered in practice.

Conclusion

The Individualized Family Service Plan reflects a growing awareness of the needs of families by the federal government. **The emergence of IFSPs as an organizing factor in early childhood intervention services is an opportunity for family therapists to join with other professionals who work with families with children with disabilities. This opportunity exists for those family therapists who take the time to become familiar with early intervention service delivery and build professional relationships with early childhood interventionists.**

REFERENCES

Deal, A. G., Dunst, C. J., & Trivette, C. M. (1989). A flexible and functional approach to developing individualized family and support plans. *Infants and Young Children, 1*(4), 32-43.

Johnson, B. H., McGonigel, M. J., & Kaufmann, R. K. (1989). *Guidelines and Recommended Practices for the Individualized Family Service Plan.* National Early Childhood Technical Assistance System and the Association for the Care of Children's Health, U. S. Department of Health and Human Services; Washington, D. C.

McBride, S. L., Brotherson, M. J., Joanning, H., Whiddon, D., & Demmitt, A. (1993). Implementation of family-centered services: Perceptions of families and professionals. *Journal of Early Intervention, 17*(4), 1-17.

McGonigel, M. J., & Garland, C. W. (1988). The individualized family service plan and the early intervention team: Team and family issues and recommended practices. *Infants and Young Children, 1*(1), 10-21.

Public Law 99-457 (1986). Part H, Individuals with Disabilities Education Act, 20 U. S. C. Section 1400-1485 (Supp. 1990).

Turnbull, A. P. (1988). The challenge of providing comprehensive support to families. *Education and Training in Mental Retardation, 23*(4), 261-272.

DIRECTIONS IN MARRIAGE AND FAMILY THERAPY © 1994, The Hatherleigh Company, Ltd.
All rights reserved. Not to be reprinted without permission of the publisher.

Special Program Coordinators: Dennis A. Bagarozzi, PhD, Frederic Flach, MD

Editorial Board of Consultants: James Alexander, PhD; Stephen Anderson, PhD; Judith I. Bagarozzi, MS; Insoo Kim Berg, MSSW; William J. Doherty, PhD; Craig Everett, PhD; Charles Figley, PhD; Alan S. Gurman, PhD; Harvey Joanning, PhD; Florence Kaslow, PhD; James F. Keller, PhD; Luciano L'Abate, PhD; Pieter le Roux, PhD; Howard Liddle, PhD; Mel Markowski, PhD; Fred P. Piercy, PhD; Lynda Dykes Talmadge, PhD

Managing Editor: Debra E. Cermele

Associate Editor: Steven L. Pessagno

Directions in Marriage and Family Therapy is a continuing education program published by The Hatherleigh Company, Ltd., 420 East 51 Street, New York NY 10022. For additional information, please call 800-367-2550 or 212-355-0882 (outside the US).